HEALTH RESOURCES AND SERVICES ADMINISTRATION THIRD-PARTY REIMBURSEMENT

FINAL REPORT

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EXHIBITS

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CHAPTER I

INTRODUCTION

1. BACKGROUND AND PURPOSE

As the lead Federal agency responsible for funding the delivery of ambulatory health services to America's most vulnerable populations, the Health Resources and Services Administration (HRSA) has traditionally provided grant dollars directly to local entities or, through block and formula grants, to States and cities. Congress and the administration have anticipated that funding for the delivery of health services to vulnerable populations would come from both the appropriations/grant process and third-party insurance coverage programs, e.g., Medicaid, the Children=s Health Insurance Program (CHIP), Medicare, and some

commercial insurance. The Federal policy position has been that third-party insurance should pay for the cost of health care for insurance program beneficiaries, thereby allowing Federal grant dollars to be focused on the health care of the uninsured and underinsured.

In the summer of 1999, HRSA contracted with Birch & Davis Associates, Inc. (B&D), to conduct a third-party reimbursement maximization technical assistance needs assessment of HRSA grantees. This called for determining whether grantees were in fact being reimbursed by insurance programs; if they were not, ascertaining the reasons why not; and developing strategies including training and technical assistance (T/TA) that would enhance the ability of HRSA grantees to maximize third-party revenues.

HRSA also formed a Steering Committee composed of representatives of all of its grant programs:

- Community and Migrant Health Centers (C/MHCs)
2. Office of Rural Health Policy (ORH)
- Health Care for the Homeless (HCH)
- HIV/AIDS Ryan White Title III
- Maternal and Child Health (MCH)
- Healthy Start (HS)

The project Steering Committee selected the following three States in which to conduct the project:

- Michigan
- Pennsylvania
- Texas

The Steering Committee identified nine grantees within each State, representing a cross-section of HRSA grant programs to be included in the project. These 27 HRSA grantees comprised eight community-based organizations, nine local public health departments, four local public hospitals, five teaching hospitals, and a statewide health care network.

2. PROJECT APPROACH

B&D assembled a consultant panel with extensive experience in ambulatory health care delivery to vulnerable populations, HRSA grant programs, Medicaid and other third-party reimbursement programs, health care financing, and managed care. Project team members conducted site visits to the grantees, provided initial on-site technical assistance, documented the site visits, and analyzed the project=s findings and recommendations.

The following seven factors were used to examine third-party reimbursement within the operational contexts of the grantee organizations:

- $ Medicaid/Medicare third-party provider status of the grantee
- $ Eligibility of the grantee=s patient base for third-party program coverage
- $ Medicaid/Medicare coverage of services provided by the grantee
- $ Third-party payment rate compared with grantee costs
- $ Adequacy of the grantee billing system to maximize reimbursement
- $ Impact of mandatory managed care on grantee revenue
- $ Overarching issues

The factors listed above were used to develop a uniform data collection tool that was used to support all of the site visits. The seventh factor, overarching issues, was added to identify issues or problems that did not fall within any of the initial six factors.

Between November 1999 and March 2000, site visits to 27 grantees were conducted over two or three days by project teams of two to four technical specialists. To ensure consistency and continuity among the sites, either the Project Director or the Deputy Project Director served as a Team Leader for all of the site visits.

During the site visits, the teams reviewed relevant documents and records, observed processes, and conducted open-ended individual and small group interviews on programmatic and financial matters pertaining to third-party reimbursement. To gain a comprehensive understanding of the relationship between HRSA grant program activities and funding and the overall structure and operations of the grantee organizations, B&D held discussions with the organizations= administrative and fiscal personnel (to the extent of their availability during the site visit) as well as with the program staff directly involved in the management and performance of grant-funded activities. When necessary, the project teams also provided limited technical assistance to the grantees regarding strategies that the grantees could employ to enhance third-party reimbursement.

Following each site visit, the team members prepared a report that included preliminary findings and recommendations on strategies for enhancing third-party revenue. Copies of the site visit reports were then distributed to the grantees and to the HRSA Steering Committee for review and comment.

Following completion of the site visit phase of the effort, the project team performed an extensive analysis of their overall findings regarding third-party reimbursement. To facilitate the analysis, barriers to third-party revenue maximization were classified by type of grantee, type of problem (based on 18 clusters of problem types), and whether the problem was perceived to be under the control of the grantee, out of the grantee=s control, or ultimately out of the grantee=s control but under its influence. Exhibit I-1 shows the framework used to guide the analysis. To the extent that data were available, B&D also performed a reimbursement analysis to quantify the amount of third-party revenue that might be realized by the grantee if the problems were resolved and barriers to reimbursement were removed. The reimbursement analysis was presented to the HRSA Steering Committee in July 2000 for review and comment.

It is important to note that in the conceptualization and early execution of this project, some HRSA programs and constituencies were inadvertently omitted: school-based clinics, freestanding migrant health

centers, and Asian and Pacific Islanders. They should be included in further efforts of this nature, and resulting recommendations should be tailored to meet their unique needs.

3. CONCEPTUAL FRAMEWORK

One of the difficulties experienced in this effort was that grantee sites were not selected and the difference between the grantee organization and the grantee program was not fully determined until the project was in progress. Many of HRSA=s grantees are large institutions, while the grantee programs are often a small part of a larger organizational structure. For example, many of the Ryan White, Healthy Start, and MCH subgrantees are in fact large institutions, such as teaching hospitals and local health departments. Third-party reimbursement may be at the grantee organizational level and thus may or may not have a significant impact on the grantee program. Disproportionate Share Hospital (DSH) program payments and the Federally Qualified Health Center (FQHC) status of the grantee organization/program are good examples. In other cases (e.g., the Community and Migrant Health Centers program), the grantee program and the grantee organization are one and the same and there is not the terminological and organizational confusion seen in larger grantee organizations that house the grantee program. This report attempts to distinguish between the grantee organization and the grantee program to distill the third-party reimbursement implications, findings, and recommendations.

The second conceptual framework consideration used in this analysis was determining whether the third-party reimbursement barrier was:

- **InternalC** Within the control of the grantee
- **ExternalC** Outside of the control of the grantee
- **BothC** Potentially influenced by the grantee but ultimately outside of its control

Therefore, this report attempts to classify the third-party reimbursement barriers according to these three considerations, recognizing that the solutions and strategies will also be driven by these same considerations. As a result, recommendations in this report fall into three categories:

- For problems internal to the grantee, the recommendations are largely in the nature of training and technical assistance.

- For those external to the grantee, the recommendations are largely policy in nature.
- For those that can be influenced by the grantee but are still significantly out of its control, the recommendations are largely State-based strategies.

This report follows this conceptual framework, which is expanded upon in the findings and recommendations sections of the report.

4. THE THREE STATES

The three States selected have in common their relatively large populations and the fact that they have all initiated managed care programs. However, these States also differ considerably in terms of demographic, socioeconomic, and governmental features as well as in the manner and extent to which they have implemented Medicaid managed care, a CHIP, and State health department administration of programs and ~~resources. For a detailed examination of the health care policies and managed care approaches of these~~ three States, see Appendix C.

CHAPTER II

SITE VISIT RESULTS

5. OVERVIEW

The focus of this section is on problems facing HRSA grantees that prevent them from obtaining third-party reimbursements and on calculating what could be collected by the grantees if the problems were resolved.

The project team gathered extensive information from the grantees. The emphasis was on identify-ing problems and barriers that prevent or limit them in maximizing third-party reimbursement. The problems identified were classified under the seven factors listed in Chapter I. Using this information, we then estimated the amount of revenue that the grantees could collect if the barrier or problem were removed.

For a grantee to maximize its third-party reimbursement, it must be recognized as a third-party provider; provide reimbursable services by qualified staff; have an efficient billing system, up-to-date rates, and a formal agreement with a managed care organization in the State; and have no policy barriers to billing and reimbursement. In no case was a grantee able to fully maximize its collections. While there was a great deal of variation in the ability of the grantees to collect third-party reimbursement effectively, the site visit teams found that grantees in six of the seven programs involved in this study had opportunities for improving their third-party reimbursement. The one exception was grantee programs supported by the Office of Rural Health. While operating worthwhile and needed programs, they were providing services that were generally not reimbursable.[1]

The project team identified 18 problems or barriers preventing the grantees from collecting a substantial amount of third-party reimbursement. Using the multifactor approach, what appears below is an identification of the problems and barriers. For each, a brief discussion is presented here of the problem with an estimate of what could be collected in the future if the problem or barrier were eliminated.

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[1] HRSA grantees based at either a hospital or university presented another problem for the study team. In most cases the HRSA-supported program represented less than 1 percent of the total operating budget for the institution. Therefore, the only data available were from the department within the university or hospital that houses the program. Study team members were unable to obtain revenue data for the programs.

One of the project=s objectives was to identify problems or barriers with an impact on grantees across the country, not just on one of the States we visited. It is for this reason that in discussing the various problems and barriers, there are no references to specific sites or in many cases to the State involved. A more detailed presentation of each of the barriers, including those impacting on the sites visited, is given in Appendix A.

It should be noted that grantees face several barriers that together are preventing them from maximizing their third-party collections. In addition, some of the barriers identified are not easily quantifiable due to the multitude of problems faced by the grantee or due to lack of meaningful data. The study team is convinced, however, that if the causes were addressed, the grantees would have far greater opportunity to collect additional third-party reimbursements.

6. PROVIDER STATUS

2.1 Provider Designation

Twelve of the 27 grantees studied demonstrated problems with their third-party payor designation status that led to reimbursement barriers.

1. Licensing Restrictions **C** Licensing policies or rules established by the State Medicaid agency and other insurers do not recognize clinics that are operated on a part-time basis or are operated by the State or local health department. Such policies have created problems for grantees such as Health Care for the Homeless clinics, Healthy Start, and school-based clinics, including preventing them from billing for services.

$ **Failure to Recognize Provider Status C** Some grantees have not sought or gained status as providers of care and therefore do not accumulate sufficient cost and encounter data to produce bills for program services.

$ **Lack of FQHC Status C** Some grantee programs could enhance their reimbursements by being linked to an FQHC. For example, one Title III Ryan White CARE Act clinic is operated by a local health department that is also an FQHC. While both are divisions within the FQHC=s health department, they are administered and organized separately. As a result, the HIV/AIDS clinic does not receive cost-based reimbursement for covered services rendered to Medicare and Medicaid recipients. Management reported that the clinic has an active caseload of over 1,100 patients, most of whom are Medicaid or Medicare eligible. A direct program linkage between the two would enable the Ryan White grantee clinic to substantially improve its Medicaid/Medicare reimbursement. This could be done without either program=s loss of identity.

PROVIDER STATUS SUMMARY

Problem/Barrier	Types of Grantees Impacted
State licensing restrictions	Health Care for the Homeless, school-based clinic programs, Healthy Start
Grantee not recognizing provider status options	Maternal and Child Health subgrantees, Health Care for the Homeless
Lack of utilization of FQHC status	Health Care for the Homeless, HIV/AIDS Title III grantees, Healthy Start
Findings	Twelve of the 27 sites studied had a provider designation problem.

3. ELIGIBILITY

3.1 Inadequate Assistance In Enrollment

Eight of the 27 sites studied demonstrated inadequate patient assistance in enrollment and third-party payor programs.

- **Outstationed Eligibility Workers C** This continues to be a problem for many Federally Qualified Health Centers that are not receiving support from the State Medicaid agency. Outstationed eligibility workers were available for some but not all of the FQHCs visited.[2] In addition, the study team found that many grantees were not providing adequate enrollment assistance for their clients or were missing enrollment opportunities for their clients. This was especially true at homeless clinics.

- **Lack of Forms C** In some cases, the grantee=s ability to be fully supportive was limited by State policy or regulation. The barriers found by the study team include not having or being allowed to have Medicaid applications at the clinic. In one State, the application could only be obtained and completed at a State office.

- **Lack of Coordination C** Compounding the problem of not having staff available to assist clients, some grantees were not taking advantage of the opportunity to work with other organizations that were helping individuals enroll in Medicaid or other programs for the medically indigent.

[2] One FQHC serving an overwhelmingly Hispanic community had a State-supplied outstationed eligibility worker who did not speak or understand Spanish.

- **Dual Eligibility**—While most of the grantees were familiar with the various programs for dual eligibles, many were not aware of the requirements and the procedures for enrolling clients in the programs. This was true even for grantees with a significant number of clients enrolled in the Medicare Program.

3.2 Eligibility Barriers

Sixteen of the 27 grantees studied had patients with a variety of eligibility problems.

- **Twenty-Four-Month Medicare Waiting Period for Social Security Disability Income (SSDI) Beneficiaries**—This significant problem impacts all individuals eligible for SSDI benefits. Federal policy prevents individuals who have been judged as disabled by the SSA from receiving Medicare coverage for 24 months. This is especially a problem for individuals with AIDS. Many individuals caught in this waiting period are also ineligible for Medicaid, since their SSDI payments exceed the eligibility limit for Medicaid.

- **Undocumented Residents**—Another problem faces HRSA grantees that are serving undocumented residents. This is not limited to Texas but exists for HRSA grantees in all three States studied. One State program serving children with special health care needs states that it will provide services to all residents of the State, regardless of their citizenship status. However, one requirement is that the parent(s) must apply first for Medicaid coverage. Since these patients are ineligible for Federal (and in most cases, State) assistance programs, grantees provide services to them without receiving reimbursement.

- **Eligibility Procedures and Requirements**—Two of the States surveyed in this study have high numbers of individuals eligible for but not enrolled in the State Medicaid programs (higher than the national average). The many reasons identified included the need for a face-to-face interview and income verification, the time involved, the multitude of forms or documents required, inaccessibility of eligibility offices, and the hostile or indifferent attitude of State staff responsible for enrolling individuals. In one State, other barriers cited were linking the Medicaid application process with the Temporary Assistance for Needy Families (TANF) application process, poorly constructed forms, and inconsistency in eligibility requirements preventing children from receiving Children=s Health Insurance Program or Medicaid coverage.[3]

- Eligibility procedures and requirements place an unique hardship upon the homeless, although health care services have been specially tailored to meet the needs of homeless

[3]Due to the enrollment procedure linking Medicaid enrollment with the State=s CHIP enrollment process, a child could be referred back and forth between the two programs and never be determined eligible for either one.

people in all three States. Priorities for the homeless population are finding shelter and food, not health care. The problems facing the homeless clinics in trying to capture third-party reimbursements are substantial. They include an inability of many homeless individuals to meet the basic requirements needed to qualify for Medicaid—a permanent address, a telephone, documentation of citizenship or employment (income), and transportation. In addition, if an individual does become qualified, there is no assurance under mandatory managed care that he or she will be assigned to the homeless clinic or that an MCO will even contract with that clinic.

3.3 Eligibility Window

Two grantees were found to not be recognizing, for billing purposes, the eligibility window between Medicaid eligibility determination and MCO enrollment.

State Medicaid managed care programs characteristically have a period of time when a recipient has been determined to be eligible for Medicaid but is not yet enrolled in a managed care organization. This time period varies by program. During this time period, Medicaid recipients may receive services and have those services paid for on the traditional fee-for-service basis. In one State, this eligibility window is approximately 45 days long. The study team found that several grantees in this State were not taking advantage of this fee-for-service billing opportunity.

PATIENT ELIGIBILITY SUMMARY

Problem/Barrier	Types of Grantees Impacted
Inadequate Assistance in Enrollment—Outstationed eligibility workers, lack of forms, lack of coordination, and dual eligibility	Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Healthy Start, HIV/AIDS Title III
Patient Eligibility—Medicare 24-month waiting period, undocumented residents, eligibility procedures and requirements	Maternal and Child Health subgrantees, Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Healthy Start, HIV/AIDS Title III
Eligibility Window—Billing for services during window between Medicaid eligibility and MCO enrollment	Community Health Centers, Migrant Health Centers
Findings	Nineteen of the 27 sites studied had eligibility-related problems.

4. COVERED SERVICES

4.1 Lack of Staff Certification

The problem of the lack of staff certification was raised in two of the three States visited. The problem is the same in each State**C**the State requires case managers or programs to be certified by the State. Seven of the 27 sites had problems identified in this area.

In one State, all types of case managers are required to be certified in order to bill for their services. Five grantees in this State provided case management services without having their staff certified, thus preventing them for billing for these services. In the second State, the requirement for staff certification for case management is more specialized. Program certification is required to provide case management services to clients served through maternal support services and infant support services targeting high-risk pregnant women and their children. Two of the grantees did not have staff certified to provide these services but were actually providing at least some of these services to clients.

4.2 Deficient Waiver and Case Management Coverage

Twenty-two of the 27 grantee sites visited had deficient waiver and case management coverage. Appendix B contains an overview of reimbursable Medicaid case management services.

- **Home and Community-Based Services Waiver: Lost Opportunities**C Home and community-based care is increasingly viewed as a alternative to long-term institutional care for persons who have significant limitations in performing daily living activities. Home and community-based services waivers, also called 1915(c) waivers, are one of the tools used by State Medicaid programs to provide long-term care to qualified individuals in noninstitutional settings. By serving individuals through waivers, States have more flexibility in their long-term care programs and beneficiaries can receive health care in settings that are more comfortable for them.

  In establishing the 1915(c) waiver program, Congress sought to prevent or postpone institutionalization of persons who could be served equally well within the community. With approved waiver programs, States are authorized to cover a wide variety of nonmedical social and supportive services that have been shown to be critical in allowing persons to remain in the community. Examples of such services are homemaker services, adult day health services, minor home modification, and respite care.

  The three States involved in this study have a total of 22 approved 1915(c) waivers. Twelve of the waivers are to provide services to individuals with developmental disabilities. Only three waivers have been approved for clients most likely to be served by HRSA grantees. There is only one waiver for individuals with HIV/AIDS, and there are two for children with special health care needs (one for technology-dependent children and the other for Amedically fragile@ children under one year of age).

All three States are using State-only dollars to provide supportive services that could be provided through a 1915(c) waiver. The States are underwriting 100 percent of the cost of these services. By either expanding an existing waiver or creating a new waiver, the State could more than double the scope of its activity without additional dollars.[4]

- **Services Not Included in an Existing 1915(c) Waiver for Children with Special Health Care Needs C** One State is using both Title V and State general funds to pay for services being provided to children with special health care needs. The State has a 1915(c) waiver to provide services to these children. The waiver pays for case management services, private duty nursing, and medically necessary equipment. The Health Department is paying for respite, home health, and other services to families included in the waiver. These services should instead be included as covered services under the waiver. The Department could thus more than double the amount of services it is currently providing without costing the State any additional dollars.[5]
- **Not Recognized as a Provider of Waiver Services for High-Risk Pregnant Women and Their Children C** One State has an approved 1915(b) waiver for high-risk pregnant women. This waiver was established prior to its managed care waiver and is still operational, although such services are now the responsibility of the MCOs. For communities not included in the Medicaid managed care program, the State contracts with a limited category of providers to offer the waiver services. Unfortunately, local health departments and Healthy Start projects are not recognized as providers of services,[6] despite having provided case management services to women previously. In fact, one Healthy Start project has been negotiating with the local MCO for several years but has been unable to come to any agreement.

In another State, the Department of Health offered two programs prior to the establishment of its Medicaid managed care program. The first offered enhanced services to high-risk pregnant women, and the second offered enhanced services to their high-risk children. Both programs were subsequently incorporated into the State=s managed care program. These services now must be provided by qualified medical providers (QMPs). Local health departments and Healthy Start projects are providing these services to women enrolled in the Medicaid program but are not being reimbursed. These organizations are not recognized as QMPs. The QMPs are unwilling to contract with them, yet they are referring the women to both local health departments and Healthy Start projects, which provide care without reimbursement.

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[4]The FMAP rate for each of the three States is greater than 50 percent.

[5]The State=s FMAP rate is 53.82%.

[6]Providers are limited to physicians, midwives, RHCs, FQHCs, hospitals, and outpatient departments.

- **Not Reimbursing for Targeted Case Management Services for HIV/AIDS.** As noted earlier, one State has included in its plan targeted case management services for eligible recipients with AIDS or symptomatic HIV. The State has established a certification procedure for case managers. The HIV projects in the State provide case management services to eligible clients, but Ryan White grantees are not currently billing for these services.

  A second State has also opted to include in its plan targeted case management services. According to State officials, it is possible for an individual with HIV/AIDS to be eligible for case management services. Unfortunately, it was not possible to determine how he or she would be eligible, since the State plan does not provide clear criteria for determining eligibility. Information available through HCFA's regional office indicates that most of the individuals determined to be qualified are adults with physical disabilities or who are elderly. Individuals with HIV/AIDS, it appears, are not covered. This confusion obviously affects reimbursement.

- **Not Reimbursing for Services to Children with an Elevated Blood Lead Level.** Most of the local health departments and some community health centers we visited were providing case management services to children with an elevated blood lead level. The local health departments are providing screening, environmental assessment, and case management services to families with such children. The States visited are not complying with the HCFA directive that they reimburse providers for all three lead-related services.[7] Appendix C contains a copy of the HCFA directive.

  The project team, in reviewing data from two of the three States, was able to estimate that approximately 7,000 children with an elevated blood lead level were receiving case management services and that more than 5,500 environmental assessments were being performed by local health departments without any Medicaid reimbursement. Data were available from only one local health department in one State. This Department was providing similar services to over 800 children and was not being reimbursed for providing the services.

4.3 Services Not Reimbursed

A number of problems were found regarding the delivery of services for which there was no reimbursement.

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[7] See Medicaid Directors' letter issued on October 22, 1999.

- **Lack of Coverage for Tuberculosis Services**C Public health clinics and especially health departments have traditionally been required to provide treatment to all individuals with tuberculosis, regardless of the person=s insurance status or MCO enrollment. Since 1993, States have had the option to include coverage for persons infected with TB in their Medicaid plan. Individuals with TB are eligible for Medicaid coverage simply because of the illness. The problem facing many grantees is not with the State Medicaid agency but with commercial insurers who deny payment because they feel that the health care for these TB patients is the responsibility of the local health department. While not a widespread problem, this has been identified as a problem at least once in each State. Nearly all States have removed the requirement that tuberculosis be treated solely by the State or local health department.

- **Inability or Unwillingness to Bill for Immunizations**C Several local health departments regularly provide immunizations to both children and senior citizens. Due either to their lack of billing capabilities or to local policy, many local health departments are not billing (even Medicare) for this service. Small local health departments have neither the infrastructure nor the expertise to bill for services rendered. Furthermore, program management questions the net return on such billing when compared with the investment that would be required to implement billing and collection functions. However, in many cities the potential reimbursement for these services would far exceed the billing cost. Some cities use billing agents on contract to obtain these reimbursements.

4.4 Nonreimbursable Staff

The problem of nonreimbursable staff was identified in all three States. A homeless services grantee and several programs operated by local health departments were unable to bill because they did not have a physician. A second grantee provides obstetric services, but the MCO that it contracts with does not recognize family practice physicians or midlevel practitioners as valid providers of services.

COVERED SERVICES SUMMARY

Problem/Barrier	Types of Grantees Impacted
Staff CertificationC Not seeking or gaining staff/program certification for case management	HIV/AIDS Title III, Healthy Start
Deficient Waiver and Case ManagementC Services not included in a 1915(c) waiver *or* waiver services to high-risk pregnant women and children *or* targeted case management for HIV/AIDS *or* not reimbursing for lead services	All Community Health Centers and Migrant Health Centers (local health departments are particularly impacted by lack of coverage for children with an elevated blood lead level even though specified in the Federal statute).
Services Not ReimbursedC Confusion over and lack of	Community Health Centers, Migrant Health Centers,

Problem/Barrier	Types of Grantees Impacted
coverage for tuberculosis services in spite of Federal and legislative language in Medicaid and commercial payor responsibility	HIV/AIDS Title III, Health Care for the Homeless, MCH subgrantees
Nonreimbursable staff	Community Health Centers, Migrant Health Centers, Health Care for the Homeless, MCH subgrantees
Findings	Twenty-two of the 27 sites studied had problems in the area of covered services, mostly in case management.

5. RATES AND COSTS

Twenty-one of the 27 grantees reported problems with gaps in the cost of services versus the rate of payment from third parties.

5.1 Deficient Reimbursement Rates

Eight of the 27 grantees site visited demonstrated problems with third-party rates not covering grantee costs due to deficient rates by the payor.

Deficient reimbursement rates were identified by the Ryan White and homeless program grantees we visited as a major problem. State Medicaid agencies have the opportunity to identify HIV/AIDS patients and pay higher rates for their care. In the three States studied, however, enhanced rates for HIV/AIDS, homeless, and other services have not been adopted by the State Medicaid Program. While one State has adopted an inpatient risk pool arrangement, the grantees did not report benefitting from this strategy. The HIV grantees studied shared experiences reported throughout the United States. With a few exceptions, most States continue to use rate structures generated by standard methodologies for Aid to Families with Dependent Children (AFDC) that do not adjust for clinical case mix.

Managed care plans have been observed to provide inadequate rates for HIV/AIDS care in several ways. Some are not interested in contracting with HIV clinical programs, such as the grantees studied. Some offer extremely low subcapitation rates to grantees. Alternatively, some contract only with providers who are willing to accept low payments. Several of the grantees accepted low payments because they had other sources of revenue, such as grants, resulting in a cost shift from Medicaid to HRSA grant dollars. Several HIV/AIDS grantees also expressed concern that their patients might be treated by inexperienced providers if the grantee were to stop contracting with the MCO. Homeless services grantees reported decreasing patient access and increasing hospital emergency room (ER) use.

Despite some grantee efforts to gain cost recognition in payor rates, Ryan White grantees such as the ones visited during this effort continue to participate in Medicaid managed care programs that do not risk-adjust

their rates for HIV/AIDS patients. As a result, MCOs receive standard rates based only on public assistance category, age, gender, and geographic service area. For Medicaid AFDC/ TANF recipients with HIV/AIDS, those rates are likely to be at least $1,500 to $2,000 less than the actual cost to provide the nationally recognized standard of HIV care. While SSI rates are slightly higher, they are still likely to be at least $1,000 to $1,500 less than the cost of care for HIV/AIDS patients.

Homeless services grantees have not utilized their FQHC status, which could give them reasonable cost payment protections under managed care.

5.2 Inadequate Cost and Charge Setting

Fourteen of the 27 HRSA grantees whose sites we visited were found to have inadequate accounting and cost/charge-setting procedures or capability, including:

- The absence of any or accurate costing practices that would allow the grantee to determine the cost of service provision and, thus, calculate and bill sufficient charges.
- Reimbursement rates that do not appear to include the cost of specialized, allowable services provided by the grantee.
- Allowable costs that exceed established charges.
- Allowable costs that exceed an externally imposed reimbursement ceiling.
- Allowable costs that were not included in the provider=s cost report and therefore have not been reimbursed.
- Four of the 15 grantees also have cost- and charge-setting inadequacies the resolution of which is deemed outside of their control. They do have established reimbursement rates for primary care services; however, those rates do not include the cost of allowable specialized careCand reimbursement for Medicaid-allowable services does not cover costs.

The project team was unable to develop meaningful estimates for hospital- and university-based grantees. An example is a maternal and child health subgrantee at a large medical school that does not keep records in a way that would allow it to distinguish the cost of providing MCH services from that for other outpatient services. Administrators at the school estimate that it receives only 60 percent of each dollar that it bills the State for MCH services. It seems reasonable to assume that the institution would benefit from a more accurate accounting of the cost of providing MCH services and renegotiation with the State to ensure that it receives full cost reimbursement for the provision of such services.

5.3 Deficient FQHC Wraparound Payments

Four of the 27 grantees studied identified a deficiency in the State=s implementation of Federal FQHC/RHC wraparound payment protections.

The problem of deficient wraparound payments was raised by grantees in all three States in conjunction with discussion on the implementation and operation of the Medicaid managed care programs in these States. Where Medicaid managed care programs are in place, grantees that have FQHC/RHC status are guaranteed to receive reasonable cost-based reimbursement from Medicaid/Medicare for the services provided to their clientele. The 100-percent Federal reasonable cost reimbursement rate declines to zero over the next five years.

One State=s FQHC reimbursement policy, in concert with Federal law, calls for annual declining rate reduction ceilings over the next three years. At present, one grantee receives 100-percent cost-based reimbursement for services rendered to Medicaid recipients. However, the grantee expects to lose $3 per visit next year and an additional $8 per visit the following year. Another FQHC is located in a State that limits reimbursement for FQHC administrative costs to 30 percent of overall costs. This grantee=s administrative cost has exceeded this cost ceiling by approximately $135,000 in each of the past three years. These costs were disallowed in part because the grantee inappropriately classified patient care costs as administrative expenses. As a result, the grantee lost Medicaid reimbursement, which demonstrates that grantees more often experienced multiple reimbursement problems.

RATES AND COSTS SUMMARY

Problem/Barrier	Types of Grantees Impacted
Deficient Rates C Rates of reimbursement do not reflect the costs of care.	All, particularly HIV/AIDS and Health Care for the Homeless grantees
Inadequate Cost and Charge Setting C Costs are not in line with charges.	All
Deficient FQHC/Rural Health Clinic Wraparound Payments C Full costs not guaranteed over time.	Community Health Centers, Migrant Health Centers, Health Care for the Homeless (FQHCs), and Rural Health Clinics
Findings	Twenty-one of the 27 sites studied had rate/cost differential problems.

6. BILLING SYSTEM

Twenty-three of the 27 sites visited experienced billing systems-related problems.

6.1 Inadequate Billing

Inadequate billing was one of the most pervasive problems encountered during the site visits. It is also one of the most easily correctable difficulties. Seventeen sites had inadequate billing. There are many reasons, including inadequate recordkeeping (discussed elsewhere in this section), not billing for all services provided by grantees (5 of the 27 sites studied), improper logging in of clients, and incorrect or missing of information in bills to third-party insurers and other inadequate accounting and recordkeeping problems were found in 18 of the 27 sites visited.

6.2 Lack of Billing

Five of the 27 grantees did not bill for services at all and did not see its value. As an example, one grantee first became aware that it could bill for a specific service (transportation) during the site visit. This grantee was not aware that the service was included in the State Medicaid plan but carved out of the State=s managed care contracts.

6.3 Inadequate Accounting and Recordkeeping

As indicated earlier, these problems include accounting systems insufficient to generate billing and patient/encounter tracking and recordkeeping inadequate to document billing; 18 of the 27 grantees had problems in this area.

BILLING SYSTEMS SUMMARY

Problem/Barrier	Types of Grantees Impacted
Inadequate Billing C Billing systems insufficient to generate and document thorough and accurate billing to third parties.	All
Lack of Billing C Grantee has never developed the infrastructure to bill third parties at all, given no incentives to do so.	Health Care for the Homeless, Healthy Start, Maternal and Child Health
Inadequate Accounting and Recordkeeping C Insufficient accounting and patient/encounter tracking to generate and document billing	All
Findings	Twenty-three of the 27 sites studied had 40 distinct problems in the billing area.

7. DEFICIENT MANAGED CARE CONTRACTING

At least 18 grantees were deficient in managed care contracting. In most cases, the difficulty was that the managed care organizations would not contract with the grantee. The tactics used by the MCOs included

establishing difficult credentialing requirements or procedures; a never-ending dialogue between the MCO and the grantee; never being willing to discuss or offer a contract; establishing very difficult conditions in contract negotiations; and nonresponse to grantee inquiries. In most cases, the State Medicaid Agency does not assist the grantees in this process. One State, however, played a very active role in contract negotiations between the local MCOs and the HRSA grantee. This factor was very difficult to isolate and quantify and is often mixed with other factors in this analysis.

Some participating MCOs are not interested in contracting with or paying for programs for case management services rendered to plan enrollees. One State argued that the costs for covered case management services are included in the capitation rates paid to the MCOs. The MCOs argued that either the services are not covered or the MCO is directly providing the service or contracting with others to provide the service through a Agatekeeper@ delivery system.

DEFICIENT MANAGED CARE CONTRACTING SUMMARY

Problem/Barrier	Types of Grantees Impacted
Deficient Managed Care Contracting C MCOs unwilling to contract with grantees, grantees have no negotiating leverage with MCOs	All HRSA grantees presently in managed care market areas and those targeted for managed care initiatives in the future
Findings	Eighteen of the 27 sites visited had managed care contracting problems.

8. OVERARCHING ISSUES

Twenty of the 27 sites studied reported problems in this overarching issues factor area.

8.1 Unfavorable Policies, Regulations, and Legislation

Fifteen of the 27 sites visited reported one or more unfavorable policy problems impacting on their third-party reimbursement. The following represents the wide array of problems identified in this factor area.

Persons who are homeless and individuals recently certified as being eligible for SSDI (especially HIV/AIDS patients) face barriers that are beyond patients= or the grantees= control. While homeless clinics were established in recognition of the unique problems facing the homeless, similar adjustments have not been made to facilitate paying for the services provided to homeless citizens. Medicaid, Medicare, and other insurers have not adjusted their rules or their policies to reflect the unique problems faced by clinics serving populations such as persons with HIV/AIDS.

Migrants also have significant problems enrolling for and/or receiving Medicaid services. The eligibility criteria and enrollment process make it almost impossible for migrants or their families to be enrolled in a State=s Medicaid Program. The Migrant Hospital Demonstration Project, started in the late 1970s, was an attempt to provide coverage to migrants and their families while they were working. Unfortunately, this program was discontinued.

Third-party payors are not taking into account the access problems and the higher costs of providing care to certain special populations, such as HIV/AIDS patients, the homeless, and those for whom English is not a first language, in establishing their rates of payment.

Medicare does not recognize FQHC/RHC physician visits and costs when the FQHC/RHC provider sees the patient in the hospitalCthis results in a lack of reimbursement for these services.

HCFA recently issued regulations restricting hospital OPD billing status (cost-related facility fee billing rates) to clinics Aon the hospital campus.@ Large hospital grantees that have increased access through off-site clinics thus have severely limited Medicare/Medicaid reimbursement.

Late payment by Medicaid or its MCOs (in the case of managed care) creates serious cash flow problems, particularly for smaller grantee organizations. One State had not taken advantage of the Asix-month lock-in@ opportunity in Medicaid managed care, meaning that patients could change plans month to month, resulting in grantee billing chaos.

Inefficient Medicaid/CHIP eligibility determination by States and managed care enrollment by MCOs/States can represent significant loss of third-party revenue unless the State allows retroactive billing back to the date of patient application.

Some States have deployed Medicaid presumptive eligibility (PE) for pregnant women and their children, but not all grantees have become PE providers, nor does PE presently include other patient populations. Newborn eligibility determination was also identified as a problem. Grantee billing systems are not always sophisticated enough to pick up retroactive billing and reimbursement opportunities.

Confusion over the policy regarding Afirst or last dollar@ payment by Medicaid or grant is still widespread, particularly in the MCH block grant program at both the State and subgrantee levels. This can result in a significant cost shift from Medicaid reimbursement to HRSA grant dollars.

8.2 Medicaid State Matching Problems

Nine of the 27 sites visited reported problems with State Medicaid matching strategies that negatively impacted the grantees= third-party reimbursement.

- **Using Medicaid Matching Funds C** Several grantees reported that their State Health Department does not allow them to bill Medicaid. All documentation of services is forwarded to the Department, which in turn bills and gets reimbursed by Medicaid. It is reported that very few of these dollars come back to the local health department. It is to the State=s advantage to do the billing and retain the Medicaid matching funds. Unfortunately, this places an unnecessary burden on the local health departments and requires local dollars to support State operations. Another State has a similar policy of using local hospital district tax funds to draw down additional Federal Medicaid dollars, but the return to the grantee organization is not always commensurate with the amount assessed. A third State matches Federal dollars with local tax dollars to provide the local health departments with Areasonable cost@ features in its Medicaid payment policy, but only for the Federal Medicaid share portion.

- **Using State and Local General Funds C** Several States are using traditional public health dollars to satisfy the matching requirements of Medicaid programs and/or the CHIP. In one State, local hospital districts are required to provide the State Medicaid Agency with matching funds. The problem for public health agencies is that when their tax dollars are used for matching purposes, they do not necessarily receive their share of the Medicaid funds. This can be a double hit on local or even State health departments. Prior to such Ataxing@ by the State Medicaid Agency, the State or local agency had control over the use of its general funds. With the required contribution to Medicaid for matching, they not only lose control over how the funds are to be spent, but they also do not proportionately receive or control the Federal Medicaid money that their funds have generated.

- **Administrative Case Management C** State and local health departments and other HRSA grantees working with their Medicaid Agency have an opportunity to bill Medicaid for performing functions A. . . necessary for the proper and efficient operation of the Medicaid State plan.@ This administrative case management billing enables them to bill for activities that assist the Medicaid Program but are not classified as direct services. Activities covered under administrative case management can include assisting a non-Medicaid recipient, outreach activities, eligibility assistance, and educational activities. Unlike direct services, the Medicaid match is limited to 50 percent unless the staff involved are health professionals, and then the match is 75 percent. Billing under administrative case management is allowed under a collaborative agreement with the State=s Medicaid Agency.

  Two States involved in this study were billing under the administrative case management option. One State limited billing to activities at the State level; local health departments and others are not allowed to participate in the program. The second State has been allowing local health departments to participate since 1994.

While administrative case management presents an excellent opportunity for both HRSA grantees and State and local health departments, HCFA requires a substantial amount of documentation prior to approving administrative case management bills. Unfortunately, one State has erected many barriers that make it almost impossible for the local health departments to benefit. Most of the requirements the State has established either are unnecessary or go beyond HCFA=s requirements. In addition, the State has been reluctant to do the required audit of each bill, effectively preventing the local health department from receiving any reimbursement. One local health department had outstanding administrative case management bills from 1994. As a result of technical assistance provided during the site visit, the two local health departments actually received partial payment from the State.[8]

There is an apparent negative attitude at both the State Medicaid agencies and many regional HCFA offices toward allowing administrative case management billing. This position on the part of the State Medicaid agencies is difficult to understand. Billing under the administrative case management option may not cost the State any additional dollars and does not impact any 1915(b) or 1115 budget neutrality ceiling. It should be noted that many State and local health departments, with the assistance of their Medicaid agency and HCFA, have been successfully billing using the administrative case management option.

The States studied had provided more than the required match for the MCH and Ryan White Title II block grants. The amount of the overmatch would be better utilized by matching it with Federal Medicaid dollars to expand services.

- **$ Overmatching Federal Grant Programs/Undermatching Medicaid.** Federal grant programs sometimes require matching State dollars (e.g., MCH) or have Amaintenance of effort@ requirements for the State, e.g., Ryan White Title III. The States, in overmatching their Federal grant requirements, are losing the benefit of leveraging Federal Medicaid dollars.

8.3 Disproportionate Share Hospitals

Several grantees visited by the study team either are hospitals receiving disproportionate share hospital funding or are affiliated with such an institution. The tactics used by States to draw down Federal DSH dollars, the distribution to hospitals within the State, and the resulting congressional cutback in DSH funding has forced the hospitals to re-examine the types of programs they are supporting and/or the extent of support they are giving to these programs. The reduction in DSH financing has a potential impact on all HRSA grantee programs sponsored by DSH hospitals, including several Healthy Start projects,

[8] One local health department was billing over $1 million annually under the administrative case management option. Due to inadequate data collection on its part, it will receive only $200,000 from Medicaid. A second local health department, with better documentation, received over $350,000 from Medicaid.

HIV/AIDS clinics, Maternal and Child Health programs, and homeless projects. Nine of the 27 grantees visited in this study are DSH hospitals, and this figure does not include grantee subcontractors that may be DSH providers as well.

OVERARCHING ISSUES SUMMARY

Problem/Barrier	Type of Grantees Impacted
Unfavorable Policy, Regulations, and Legislation C A variety of State and Federal policies have an inadvertent negative impact on grantee third-party reimbursement.	Community Health Centers, Migrant Health Centers, Health Care for the Homeless, HIV/AIDS Title III, Maternal and Child Health subgrantees, Healthy Start
State Medicaid Matching C State matching strategies don=t always benefit the grantee or maximize the Federal Medicaid drawdown of dollars for the State.	Grantees that are State and local health departments and/or hospital districts
Disproportionate Share Hospital Payments C This special Medicaid payment to grantees (hospitals) has been severely cut back, threatening the grantee organization and its support of grantee programs.	HIV/AIDs, Health Care for the Homeless, Healthy Start, and Maternal and Child Health subgrantees that are DSH hospitals or that have subcontractors with DSH hospitals
Findings	Twenty of the 27 sites studied reported problems in this overarching issues category.

Appendix D, Untangling DSH**C** A Guide for Community Groups to Using the Medicaid DSH Program to Promote Access to Care, prepared for The Access Project, a Robert Wood Johnson Foundation initiative, presents approaches to maximizing access to health care services through the use of DSH funding.

9. SUMMARY

Data collected by the project team from the 27 site visits show that for all types of HRSA grantees, there are opportunities for additional third-party collection. Some grantees, particularly Community Health Centers and Migrant Health Centers, have been fairly successful in billing and collecting from third-party payors. Other grantees have made little or no effort to bill or collect from third-party payors, as the incentives, policy direction, and grantee infrastructure are inadequate.

The team identified 18 problems and barriers preventing grantees from successfully billing and collecting third-party reimbursements. Seldom was there a single problem or barrier that prevented the grantee from collecting reimbursement. In most cases several problems needed to be resolved before the grantee could collect additional funds from third-party payors.

The project team believes that the problems and barriers identified in this chapter are not limited to a specific grantee or unique to the States in this study. It is likely that the kinds of barriers and problems identified are faced by HRSA grantees throughout the country.

CHAPTER III

INTERPRETATION OF FINDINGS

Within the seven-factor framework discussed in Chapter I, this chapter interprets the project=s findings. These include the 18 problems noted above, including issues of importance concerning third-party payments. The project findings are accompanied by considerations of actions that might be taken to enhance third-party payment. Together, they form the basis for the conclusions and recommendations presented in this report=s fourth and final chapter.

10. THIRD-PARTY PROVIDER DESIGNATION

The first factor in this analysis is the third-party provider designation. Medicare and Medicaid classifies its provider types in Federal statute and often designates the payment methodology for the provider type. Examples include: hospitals (DRGs for inpatient care), outpatient departments (OPD facility rates based on a cost-related payment methodology), physicians (fee-for-service), home health agency (reasonable cost methodology), and FQHC/RHC (reasonable cost methodology). It has long been recognized by third-party payors that the financing mechanisms drive provider behavior in the health care system. For example, when HCFA put hospital inpatient care on the DRG payment system as a cost containment device designed to reduce inpatient utilization, it kept the OPD payment method on a cost-related basis in order to encourage more outpatient care.

The HRSA grantee=s third-party provider designation, then, is an extremely important determinant in the rate of reimbursement the grantee receives. To the extent that the grantee has provider designation options in existing Federal statute/regulations or that could be proposed in payment policy, these should be explored. A case in point is the FQHC provider type which some HRSA grantees (C/MHCs and homeless grantees) automatically enjoy by virtue of deeming language in Federal statute. In addition, grantees could apply for FQHC look-alike (FLA) status by demonstrating that they meet Federal FQHC standards and can therefore also enjoy reasonable cost reimbursement. It is interesting to note that some of the sites in this study had FQHC status but had not embraced this provider designation in order to enjoy the payment benefits. Other sites had provider/payment options which they had not explored.

The findings and considerations for this third-party provider designation factor are found in Exhibit III-1.

2. PATIENT ELIGIBILITY ISSUES

Patient eligibility issues represent widely diverse patient circumstances and constantly changing eligibility criteria and procedures. It is a very basic factor in third-party reimbursement; if the patient is not eligible and enrolled, then the grantee/provider cannot expect to be reimbursed. The complexities of changing eligibility criteria and procedures place significant demands upon the grantees to Akeep up@ with changes. The patient population the grantee serves also presents eligibility complexities that vary with the type of grantee. For example, a MCH grantee serving low income pregnant women and children is likely to have a much higher proportion of Medicaid eligible patients than is a migrant health center or a homeless health care grantee whose patient base is less likely to be Medicaid eligible. The three problem areas addressed in this report are:

- **Not Recognizing the Eligibility Window C** This problem area represents the lost opportunity for billing in Medicaid managed care environments for services provided to patients between the period of Medicaid eligibility determination and managed care plan enrollment. One state in this study had a policy of paying fee-for-service for 45 days during this transition period and 2 of the 9 grantee sites visited in this State were not taking advantage of this opportunity.

- **Inadequate Assistance in Enrollment C** This problem area encompasses the difficulties grantees experience in assisting their patients in eligibility screening, accumulating required documentation and moving through a sometimes arduous process of eligibility determination and enrollment with the patient and the Medicaid/CHIP/Medicare programs. Special eligibility features , such as Medicare's Qualified Medicare Beneficiary (QMB) Program or End-Stage Renal Disease (ESRD) patient eligibility, or Medicaid's outstationing of eligibility workers or Presumptive Eligibility (PE) can often go overlooked. Linguistic and cultural sensitivity are important dimensions of this problem area.

- **Eligibility Barriers C** Patient characteristics, such as immigrant status, homelessness, English as a second language, etc. are often barriers to meeting Medicaid/CHIP eligibility criteria or procedural requirements. Complicated and lengthy eligibility determination can inhibit patients from seeking eligibility for the third-party reimbursement programs.

The findings and considerations for this eligibility barriers factor are found in Exhibit III-2.

3. COVERED SERVICES

Covered services is one of the most complex of the seven factors and is rampant with terminology and definitional problems emanating from long standing differences between public health terms and

definitions and those of Medicare and Medicaid as third-party payors. These terms and definitions have changed over time and are constantly being reinterpreted by various third-party payors, which makes the situation even more confusing. State licensing and certification requirements add to the confusion. The four problem areas addressed under this factor are:

- **Nonreimbursable Staff**—This problem area focuses on State certification requirements of individual providers and/or programs; reimbursement by third-party payors is then restricted to those who are certified. If grantees have not sought nor achieved this certification, third-party reimbursement is not forthcoming.
- **Deficient Case Management Coverage**—This problem area is distinguished by its multitude of terminology and definitional problems. Federal Medicaid statute alone has five different uses of the term. Confusion exists the definitions of "medical" case management versus "social services" case management, utilization control versus an enabling service, and marketing program vary from state to state and time to time complicate coverage of this service even further.

- **Services Not Reimbursed**—Some services, such as tuberculosis (TB) management, lead screening/management, behavioral health, prenatal services for the undocumented, are not reimbursed by third-party payors. This problem area emanates from statutory or certification restrictions or, more often, from third-party payors distinguishing public health services from personal health services and, then, taking the position that public health services are not covered by third-party insurance programs.

- **Lack of Staff Certification**—HRSA grantee models of delivery utilize health care personnel that are often not recognized by third-party payors to function independently (e.g., RNs) or to provide certain covered services (e.g. family practice physicians providing obstetrical services). Grantees studied did not appear to be aware of Medicare/Medicaid "incident to" provisions, that could allow recognition of and reimbursement for this type of personnel.

The overall findings and recommendations for this covered services factor are found in Exhibit III-3.

4. RATES AND COSTS

The fourth factor (rates and costs) is designed to examine the problems/barriers that contribute to the grantees' inability to obtain reimbursement at a rate that is commensurate with their costs. While the problem areas discussed in this section focus on the inadequacy of rates related to grantee costs, it should be recognized that health care cost containment policy for the last 20 years has increasingly moved to a competitive versus a regulatory strategy. Grantees must increasingly keep their costs competitive in their marketplace.

There are two ways to keep costs in line with rates of reimbursement**C** reduce costs or raise rates. Both of these approaches are taken into account in the following recommendations. While grantees must engage in strategies to reduce costs, strategies must be developed concurrently so that reimbursement rates adequately address the grantees= patient population served and scope of services provided.

The problem areas identified under this factor are:

- **$** **Deficient FQHC Wraparound C** Grantees with FQHC provider status have historically had the right to reasonable cost reimbursement under Medicaid/Medicare. The erosion of reasonable cost reimbursement for FQHCs has largely been driven by State Medicaid managed care and waiver developments. Ultimately, Congress provided statutory Awraparound@ payment protections for FQHCs which assured that the FQHC would get 100 percent of its reasonable costs from a combination of MCO payment and direct Awraparound@ payment from Medicaid. Unfortunately, at this time this 100 percent of reasonable costs slides downward over a five-year period at which point the statutory protection sunsets. Unless a substitute FQHC payment provision is established in Federal statute which keeps the rate in line with grantee costs, grantees will be forced to reduce costs by reducing patient care or shifting some of the cost of care to Medicare and Medicaid patients to grant dollars.

3. **Inadequate Cost and Charge Setting C** This problem area focuses on the grantee situation where charges are not established based upon grantee costs. This arises because grantees do not have sufficient cost accounting systems to establish charges based upon costs and/or have little or no incentive to do so given market area rates of reimbursement. As one grantee reported, charges are set at the Medicaid rate of reimbursement because Athat=s all we are going to get anyway.@

4. **Deficient Rates C** This problem area is distinguished by the fact that grantees do not always optimize their rates of reimbursement through an analysis of their third-party payor patient base, the payment options afforded them, and the cost of establishing and maintaining the infrastructure to support the option. A case in point, is a large hospital that is a homeless grantee with a very small percentage of Medicaid patients eligible/enrolled and who has an option of retaining billing as an OPD or moving to billing as a FQHC. If the FQHC rate is higher than the OPD rate but the volume of patients is low and the infrastructure costs for the shift are significant, then maybe it is not worth shifting to FQHC because the net overall gain may not be worth it.

The overall findings and recommendations for this rates/costs factor are found in Exhibit III-4.

5. BILLING SYSTEMS

This factor represents the difficulties grantees are having with the overall billing, collection, and accounting systems. Recommendations are clustered for all of the three problem areas due to the interrelatedness of the problems and the similarity of the considerations, thereby reducing repetition. The three problem areas addressed in this section of the report are:

- **Inadequate Billing C** This problem area was frequently found (17 of the 21 sites had findings) across all types of HRSA grantees and represents an Aintent to bill@ on the part of the grantee, but a lack of sufficient infrastructure (internal staffing, standards and systems) to efficiently and effectively bill and collect from third-parties in a very complex and ever-changing third-party reimbursement system. A metaphor worth presenting here is that many grantees have a sophisticated but different primitive AKool- Aid stand@ type of billing system in a third-party reimbursement system that requires minimally a AMcDonald=s@ type of operation, or they have a ADomino's Pizza@ system within a AMcDonald=s@ type of third-party reimbursement marketplace. In either of these cases, the adequacy of the billing system is not congruent with third-party payors= standards and expectations **C** and they are the ones who Awrite the checks for payment of services.@

- **Lack of Billing C** Lack of billing occurs when the grantee lacks the incentive to bill given the billing related barriers they face (see Provider Designation, Covered Services, and Unfavorable Policy, Regulations, and Legislation sections of this report for further information) or given a lack of congruency with perceived grantee mission, lack of direction/expectations on the part of the funding source, and /or lack of knowledge/skills to develop and maintain a sufficient billing infrastructure. Five of the 27 grantees were found to be in this position.

- **Inadequate Accounting and Recordkeeping C** Adequate and sophisticated accounting and record keeping are an essential foundation for any grantee/provider to maintain a billing and collections system which maximizes third-party reimbursement. Grantees do not often understand the principles and requisite accounting, data collection, and record keeping systems that must validate, support, control, and document a billing and collection system. Historical dependency on grant funding has resulted in accounting and recordkeeping that meets the needs of accountability for grant funding but not for third-party billing and collections. Some grantees have not made this transition. Eighteen of the 27 grantees in this study had shortcomings in this problem area.

The overall findings and recommendations for this billing systems factor are found in Exhibit III-5.

6. MANAGED CARE

While the scope of this project did not include a wide scale analysis of the impact of all of the dimensions of managed care developments on grantees, it did include an assessment of managed care impact on grantee third-party reimbursement. The result of these findings focused on the inadequacy of managed care contracting with its implications for grantee third-party reimbursement.

Without the foundation of strong and well-negotiated managed care contract language regarding grantee patient enrollment, covered services, and reimbursement, the grantee is virtually powerless in protecting their patient base. They are therefore, unable to argue for their services to be covered, and are unable to establish a base for the reasonableness of their rate of reimbursement. This becomes extremely difficult for grantees who serve a high proportion of patients for whom the cost of care is greater given the nature of their health care and social service related needs (e.g. HIV/AIDS, homeless, etc.). The problem is then compounded if the grantee has not done any planning, has limited managed care knowledge, and has no negotiating leverage with MCOs/third-party payors, rendering them in the least likely position to negotiate better managed care contracts.

The overall findings and recommendations for the managed care impact factor are found in Exhibit III-6.

7. OVERARCHING ISSUES

As identified earlier in this report, this factor was added to the analysis as these issues, identified in site visits, did not Afit@ uniquely within any if the six factors of the analysis but rather were overarching issues that crossed or were Aoverarching@ the six factors of the analysis. The three types of problems addressed in this Aoverarching issues section of the analysis are:

7. Unfavorable policy, regulation, and legislation
8. Medicaid State matching issues
9. DSH reimbursement problems

These are discussed below.

- **Unfavorable Policy, Regulation, and Legislation:** This problem area was identified as one in which Federal/State reimbursement policy, as articulated in Federal/State legislation, HCFA, and/or State regulation or policies and procedures, had an inadvertent negative impact on grantees= ability to secure or maximize Medicare/Medicaid/S-CHIP reimbursement. Sometimes this was an outgrowth of

unintended consequences of existing policy, lack of clear policy statements, inadequate policy development (given the reality of State and local political/marketplace forces), or the absence of policy statements altogether

$ **Medicaid State Matching IssuesC** Federal statute and regulations have always allowed states to match Medicaid Federal dollars, 50/50 for administrative costs and a service match individually determined for each state (federal share is greater than 50 percent. There is a great deal of flexibility for States in their matching arrangements under basic Federal standards. While some States have creatively used matching arrangements to expand access to services, others have missed opportunities or chosen not to take advantage of opportunities due to local considerations.

Some States provide matching funds over and above the required Federal match/maintenance of effort for State block grants (e.g. MCH, Ryan White) instead of taking the opportunity to use the amount of the Aover match@ for the Federal Medicaid Adraw down@ and Medicaid service expansion. Two of the States studied in this project had developed strategies whereby local tax dollars, either through local health departments or hospital districts, were used as local Medicaid matching dollars to Adraw down@ their Federal match. In addition, it appeared that all of the Medicaid State and federal dollars were being not fully utilized, once Adrawn down,@ for increased Medicaid services to patients or increased reimbursement to grantees for services to Medicaid patients.

$ **Disproportionate Share Hospital Reimbursement Problems C** Medicaid/Medicare DSH reimbursement was developed pursuant to the Omnibus Reconciliation Act of 1981, which is intended to support hospitals serving large numbers of Medicaid beneficiaries and uninsured/underinsured individuals, with funds/reimbursement to cover the costs of otherwise uncompensated care. State policy determines which hospitals within a State qualify as DSH hospitals under minimal Federal standards. Federal Medicaid match is available to the state at the State=s service match rate. It is estimated that the Federal government, alone, will pay out $9.2 billion in DSH payments for FiscalYear 2000. The 1997 Balanced Budget Act placed a number of restrictions on the DSH Program, such as capping the amount of DSH payments a State and an individual hospital could receive. However, the DSH program remains enormously flexible, as States are not told how much to spend on DSH or how to distribute funds among the State=s hospitals. The law simply requires that states Atake into account the situation of hospitals which serve a disproportionate number of low income patients with special needs@ by making Aadditional@ Medicaid payments to those facilities. A third of the HRSA grantee organizations in this study are DSH hospitals.

The findings and considerations for this overarching issues factor are found in Exhibit III-7.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

The previous chapter presented a seven-factor interpretation of third-party reimbursement findings that included considerations specific to those findings. In the first section below, general conclusions are given. In the second section, the considerations are reconfigured and categorized as recommendations. In the third section, suggestions are offered for operationalizing the recommendations.

$ CONCLUSIONS

A major conclusion of this project is that to a considerable extent, HRSA grantee organizations absorb the costs of providing health care services to poor people rather than being reimbursed by third-party entitlement programs such as Medicare and Medicaid. In effect, health care costs for the covered patients are being shifted from entitlement programs to HRSA grants. Moreover, although Federal policy initiatives have attempted to clarify which government entities under which circumstances should pay Athe first and last dollar,@ the project team found considerable confusion within HRSA and among the three States and the 27 grantee organizations included in this assessment in regard to first dollar/last dollar responsibility.

As an example, the project team found that this Acost shifting@ phenomenon is fostered at the Federal level by the statutory language that patients with Social Security Disability Insurance (SSDI) status must undergo a two-year waiting period to attain Medicare eligibility (except for those with end-stage renal disease). Thus, some other source is required to support the cost of their health care in the interim. In the case of uninsured HIV/AIDS patients, for example, health services are subsidized by Ryan White grant dollars for a two-year period rather than reimbursed by MedicareCeven though the patients have already been determined to be disabled by the Social Security Administration and are receiving SDI monthly income assistance checks.

At the State level, the team noted that cost shifting occurs in various ways. The State governments tend to view HRSA grantees such as FQHCs and RHCs as manifestations of Federal programs and requirements for which States should not have to take primary responsibility for cost. The States are therefore resistant to paying for care provided to their Medicaid patients by FQHCs and RHCs in accordance with reasonable cost reimbursement. Further, the States= approach to Medicaid Disproportionate Share Hospital payments is to maximize the Federal DSH drawdown without assuming concurrent responsibility for ensuring that patient care is maximized with DSH dollars.

To counter this cost-shifting tendency, a DHHS clarification and dissemination of a Alast dollar@ policy would be needed. Such a Federal policy statement would be strengthened by HRSA=s development and execution of a strategy for its grantees to enhance third-party reimbursement. This would entail using something like the Atotal budget@ concept that the Bureau of Primary Health Care employs to determine levels of grant funding to CMHCs. In this approach, grantees develop expense budgets and then project the third-party revenue that will be applied to these expenses. The level of BPHC grant funding is then determined by reviewing the expense budgets (including the projected third-party revenue) and applying BPHC funding criteria. The BPHC funding procedure underscores the notion of third-party reimbursement as Afirst dollar@ in the CMHC grant program budgeting process in a way that may well represent a viable model for HRSA grant programs as a whole.

Much confusion and many difficulties were found to result from terminological differences in the health care arena. Public Health Service language is not necessarily congruent with Medicare/Medicaid third-party reimbursement nomenclature. For example, are MCH Ahome visiting services@ really the same thing as Medicaid Acase management services@? Definitional differences between HRSA and HCFA concerning covered services, especially in regard to case management services, currently cause considerable third-party reimbursement to be lost to HRSA grantees. Contracting issues between State Medicaid programs and managed care plans have further complicated matters, because these two entities use the same terms to express different concepts. Hence, Medicaid might define case management as a facilitating or Adoor opening@ service, whereas a managed care organization might define case management as a utilization control or a Adoor closing@ function. States generate additional terminological problems by adopting local marketing jargon, such as in Pennsylvania=s Healthy Beginnings and Healthy Beginnings Plus programs, which may change from time to time, from one administration to another, or from one stage of Medicaid managed care to another. This phenomenon causes considerable confusion for patients and community providers, and in Pennsylvania and Texas it has even led to lawsuits seeking clarification of coverage.

The project team also concluded that significant barriers to enhancing HRSA grantee third-party payment lie in the variation and complexity of State Medicaid and CHIP programs. Relevant factors include:

- Variations among States in policy and budgetary dynamics driven by differences in State executive and legislative parameters

- Variation from State to State in matching Federal dollars in Medicaid, which may reflect a greater concern with State cost containment than with the provision of more health care to more persons

- Differences in State Medicaid/CHIP plans and stage of CHIP implementation, eligibility criteria and requirements, and covered services, payment provisions, and procedural requirements

- Differences in State Aamount, scope and duration@ policy requirements allowed under Federal statute and executed differently State by State

- Differences in State managed care developments and stages of execution, which have varying impacts on HRSA grantees

Therefore, HRSA grantee strategies and solutions need to effectively address State-specific health care environments and dynamics.

The project team reached a number of conclusions in regard to how the HRSA grantees are faring in a rapidly changing health finance environment:

- FQHC/RHC wraparound payments to cost set forth in the Federal statute presently protect FQHC/RHC payments, but the future is unclear; State-based implementation of Federal protections has been contentious and has resulted in some grantees experiencing shortfalls in spite of Federal statutory protections.

- DSH payments are being greatly reduced, diminishing DSH provider entities= capacity to provide care to uninsured patients. HRSA grant programs and grantees in the main do not understand DSH payment policies or know how to navigate strategically to secure the benefits of these payments for their patients.

- For the most part, HRSA granteesCFQHCs and hospitals exceptedCdo not view third-party reimbursement as a priority and do not indicate that they have a clear sense of direction from HRSA on the value of securing third-party reimbursement for services. This lack of a sense of high priority and direction has in some cases resulted in little or no billing, accounting, and recordkeeping infrastructure.

- A lack of understanding of managed care contracting represents the major Medicaid managed care difficulty for HRSA grantees. Some simply do not understand the implications and parameters of a managed care environment, and grantee impacts include being unable to contract with managed care plans in the face of plan resistance and grantee lack of leverage in contract negotiations.

- Grantee billing systems vary widely in degree of sophistication and adequacy, yet third-party payor systems have become increasingly complicated and diversified, especially with Medicaid managed care developments. Grantees thus have difficulty in responding to third-party payor requirements in an efficient and effective manner without making a major investment in billing infrastructure designed to deal with third-party reimbursement. In

addition, Medicaid Presumptive Eligibility opportunities are not being fully utilized by all grantees.

- **$** Third-party payors, in setting payment rates, do not commonly take into account the greater costs entailed in providing care to the vulnerable populations served by HRSA grantee organizations in terms of either patient mix or service mix, nor do they utilize such appropriate health financing mechanisms as risk adjustment to accommodate patient and service mix.

Finally, on the basis of their broad experience, the project team concluded that the circumstances in which the HRSA grantees find themselves and the barriers that they face are hardly restricted to the three States included in the assessment. Rather, the nature and extent of the problems encountered may be readily found all around the country. Therefore, in all 50 States, skill and flexibility will be essential for developing strategies and executing solutions that will achieve success in enhancing third-party reimbursement for all HRSA grantees**C**and thus make scarce grant dollars available to serve a greater number of vulnerable uninsured and underinsured persons throughout the nation.

2. CATEGORIZATION OF RECOMMENDATIONS

The recommendations fall into three major categories: training and technical assistance, State-based strategies, and policy considerations. Within these categories, recommendations are delineated according to the type of activity entailed.

2.1 Training and Technical Assistance

Training and technical assistance are designed to enhance the knowledge and skills of the grantee, resulting in increased capacity and infrastructure at the local level. Training and TA efforts may also be beneficial at the State and Federal levels, depending on the subject matter.

2.1.1 Training

Video training will be useful for generic topics and information sharing are but is of limited utility for specific applications of topical materials and in building the skills of grantees. It will be necessary to assess the feasibility and cost effectiveness of developing and using video training. Factors to be considered include the expense of production and the ability of grantees to learn through this medium. Potential uses for videos will be to:

11. Provide instruction on the merits and basics of the FQHC/RHC, OPD, and DSH payment methodologies and Medicaid/Medicare reimbursement

12. Demonstrate how to maximize reimbursement though the use of the window of time between Medicaid eligibility determination and managed care enrollment, including operational mechanisms for implementation; identification of grantee needs and level of interest for effective video distribution

13. Record State training sessions on eligibility requirements and technical assistance efforts for subsequent distribution to grantees for the training of staff not attending the sessions, new hires, and volunteers

14. Present case management coverage considerations, including certification

15. Address the merits of generic billing, covering HRSA expectations, and implementation considerations

National-level training will be relatively inexpensive to deliver but expensive for grantees to attend, therefore it should be conducted in collaboration with grantee national association-related meetings and conferences which they regularly attend. In national-level training, topics should be generic, The usefulness of this kind of training for grantee skill building will be limited because national meeting audiences are large and diverse. Potential uses for national-level training will be to:

6. Increase grantee awareness of the Medicaid eligibility/managed care enrollment window and the operational mechanisms to implement this internally; identify grantees requiring this training to target training audiences and needs.

7. Develop a national training curriculum on case management coverage considerations (including certification), Federal Medicaid requirements, and State options to increase grantees' knowledge of this opportunity and to stimulate them to take local action in this regard.

8. Train the staffs of State Medicaid programs and health departments in the creative use of Medicaid case management options and 1915(c) waivers as well as inform them regarding case management definitional issues and the role that HRSA grantees play in the provision of health care services.

9. Explore the formation of collaborative arrangements with national associations representing the insurance industry and health plans with Medicaid and/or Medicare contracts to provide training to Medicare fiscal intermediary personnel, State Medicaid agencies, and Medicaid-contracted MCOs that focuses on covered services, rate setting, and the reimbursement related opportunities these offer for HRSA grantees. The impact of

this training will be greatly enhanced if HRSA and HCFA successfully negotiate payment policy protections for HRSA grantees.

10. Conduct workshops at national association conferences to educate grantees about State initiatives in third-party managed care, the implications that these initiatives hold for HRSA, and HRSA=s expectations of grantees in this regard.

11. Inform grantees at national association meetings about the merits of third-party billing and related HRSA policies.

State-level training will be an especially effective method for providing training to grantees in Medicaid/Medicare third-party reimbursement and State managed care initiatives, because it can speak to the unique features of each State, it addresses more specific topics, and involves smaller grantee groups to enable them to build their skills. The training can be conducted in collaboration with State associations representing the interests of grantees together with State Medicaid agencies and State health departments. These interactions can have a synergistic effect on the development of State-based strategies (discussed later in this chapter). Potential uses for State-level training will be to:

24. Work collaboratively with statewide associations representing the interests of grantees, State Medicaid agencies, and State health departments to develop and deliver training in Medicare, Medicaid, and CHIP eligibility, documentation and enrollment; Medicaid presumptive eligibility; and QMB and SLMB requirements. The training should be based on a curriculum that will be culturally and linguistically competent and will foster program models appropriate for special populations.

25. Train grantees in Medicaid mandatory and optional case management coverage, individual State case management coverage and certification requirements, and methods for meeting the requirements in order to achieve reimbursement for case management services.

26. Provide training to the staffs of local and State health departments in the coverage of traditional public health services (such as TB and lead screening and management) by Medicaid based upon HRSA/HCFA collaborative clarification of these coverage issues. Use a curriculum that also deals with managed care considerations, and identify local health department grantees experiencing these coverage problems in order to target them for this training at the State level or possibly to Acluster@ them for regional training.

27. Identify the nature and extent of grantees= losses of revenue due to nonreimbursable staff services and render statewide training to resolve this problem through implementation of such measures as all-inclusive rate setting and delineation of Aincident to@ staff functions.

28. Continue and enhance the training provided by the HRSA Center for Managed Care by targeting the types of training curricula and types of grantees based upon the State/market area=s stage of mandatory Medicaid managed care development (such as 1915 or 1115 waivers, no-risk/PCCM versus risk-based contracting, and the presence or absence of experienced MCOs) to assist grantees in planning and positioning for managed care. Use curricula that focus on grantee positioning in a managed care environment and acquiring contract/rate-setting negotiating skills; provide training early in the managed care development process to ensure that grantees acquire and utilize the necessary skills and positioning strategies early enough to achieve the desired outcomes.

29. In collaboration with State associations representing the interests of grantees, provide statewide training to targeted grantees in current presumptive eligibility procedures within the respective States as well as in any new presumptive eligibility policies emerging from the HRSA/HCFA collaboration recommended above.

30. Deliver more billing-specific training to grantees on a State-by-State basis (in light of the differences in State-based third-party reimbursement features) in collaboration with State associations representing grantee interests and State health departments to ensure that the training is relevant in terms of grantee billing capacity.

31. Develop billing training for the Ageneric@ grantee, then develop it in separate sections to address the specific issues that may be applicable to each of the different types of grantees. Provide State-specific policy and procedures information in the overall curriculum and include the following topics: medical records documentation, eligibility tracking, encounter/charge form collection and control, coding structures, relationship between the record and billing, encounter tracking and reporting, obtaining provider billing status, acquiring a billing system, setting up billing capacity, how to staff the billing department, monitoring billing productivity, data needed in order to bill, how to track billing information, retroactive billing, accounts receivable management, Medicaid and Medicare billing, QMBs and SLMBs, how to evaluate billing services, how to manage the billing service utilized, and how to evaluate billing services versus doing your own billing.

32. Provide billing training to all grantees that are not performing proper billing, do not have automated billing systems, are not billing third parties at all, are new to billing third parties, or need to improve their billing effectiveness.

2.2 Technical Assistance

TA for the individual grantee or small clusters of grantees should be targeted in consideration of cost-effectiveness; this TA can be best used to enhance grantee skill building and problem solving. Potential uses for TA should be to:

9. Assist grantees in achieving optimal third-party provider status given their options.

10. As an outgrowth of the case management State-based strategy (described below), target for TA grantees that need individual technical assistance to position themselves better to have their case management services reimbursed and those having the most difficulty with implementation.

11. In collaboration with the HRSA=s Center for Managed Care, assist grantees in developing and executing planning and positioning strategies for an effective transition to managed care; target TA to contract negotiations with MCOs to ensure that contract language reflects the interests of the grantees and HRSA.

12. Identify grantees without any managed care positioning or contracting activities in States with active managed care programs and target these grantees for individual TA to inform them about the implications of managed care and the merits of developing a local planning and positioning strategy designed to assist grantees in the transition to managed care. Develop a local plan and a strategy for building skills to execute this plan.

13. Provide individual TA as an outgrowth of the heightened interest generated by billing training and identified grantee needs. These grantees will require their own specific (and to them, critical) problems to be addressed in a very individualized manner; problems in data flow and system configuration and operations can best be addressed by on-site TA to rapidly resolve such difficulties.

14. Ensure the availability of TA for grantees who need assistance in implementing opportunities that emerge for Asix-month lock-in,@ presumptive eligibility, newborn eligibility identification, and streamlined eligibility determination as well as for grantees that are upgrading their billing systems to accommodate retroactive billing.

15. Provide TA to HHS Regional Offices in policy clarification if HHS/HRSA/HCFA adopts a clarification of the Afirst dollar/last dollar@ policy.

TA in support of the development of State-based strategies will include provision of information, options, considerations, and facilitation in the development and execution of State-based strategies. Potential uses will be to:

- $ Provide TA under a State-based strategy to identify and analyze procedural barriers for specific populations within a State, then develop and execute a targeted collective strategy designed to remove these barriers

- $ Target TA to the grantees identified in the case management State-based strategy initiative that are having the most difficulty in achieving the desired outcomes in the context of services delivery and/or billing

- $ Target TA to grantees having difficulty in executing strategies to secure payment for work of presently nonreimbursable staff

- $ Provide TA to grantees to help them to more effectively develop, analyze, and demonstrate their costs to third-party payers to achieve better recognition of costs in rate negotiations

- $ Render TA to grantees in analyzing shared service arrangements and service expansion strategies that will result in maximizing their third-party reimbursement by spreading their overhead costs while meeting patient needs

2.3 State-Based Strategies

State-based strategies reflect the uniqueness of each State=s environment, considering the nature and extent of the problem being addressed, whether the problem can be resolved at the State level, the level of knowledge and sophistication of the State=s grantees, the viability of collective action, and the infrastructure within the State to support the effort. TA for a State-based strategy is essential to address the aforementioned and to facilitate the best outcomes:

- $ State-based collective action to build and advance arguments for congruency of State licensing and HRSA grantee access delivery models. This may receive HRSA/HCFA support and may lead to State legislative action; identify grantees with these problems in order to target efforts.

- $ Develop a collaborative State-based strategy that identifies and articulates the best arguments for the State to fully adopt eligibility enhancements, such as outstationed workers, presumptive eligibility, QMB, and SLMB; review and integrate into this strategy BPHC=s experience with State outstationing demonstrations and Americorps volunteer program priorities. HRSA/HCFA support may be necessary to achieve positive outcomes.

- Pursue Medicaid administrative case management matching to enhance resources for eligibility assistance activities.

- Identify and analyze State-based procedural eligibility barriers for specific populations within a State and develop and execute a targeted collective strategy designed to address and remove these barriers. This might be done on a pilot or demonstration basis within a few States to determine the best approaches.

- Develop a State-based strategy designed to determine case management coverage, certification, and reimbursement requirements and train grantees to achieve maximum reimbursement for case management. Identify each instance of the State=s implementation of Federal requirements and State options for case management and determine grantee participation and level of reimbursement in order to monitor State/grantee developments and outcomes.

- Grantees should collaboratively develop case management services definitions and services delivery models congruent with State Medicaid-covered services definitions and develop the capacity to maximize reimbursement potential. They should initiate a mechanism for feedback to HRSA on State developments and outcomes to better inform HRSA in its Federal policy collaborations with HCFA, to develop a national consensus definition of case management services, and to assist HRSA in clarifying case management definitions congruent with Medicaid coverage.

- HRSA should include as a part of the case management grantee identification recommended above each of the State=s chosen Medicaid targeted case management coverage options and 1915(c) home and community-based services waivers and those the State has not chosen. Once this information is transmitted to grantees, they should assess with patient advocacy groups the need for and the impact of the loss of case management/waiver coverage and formulate arguments for their State Medicaid program to maximize case management coverage potential through clarification of definitions, targeted case management, 1915(c) waivers, and other Medicaid-covered services options.

- HRSA should consider initiatives designed to stimulate grantee networking and shared services arrangements at the State and local levels. State-based strategies may then emerge and be developed and supported through State and local training and TA.

- Given the tensions that often emerge in State/local interaction concerning Medicaid local matching dollars and distribution of Federal matching dollars, identify State Abest

practices@ that create congruent incentives for State and local entities and share these best practices across the country.

- **$** Continue and enhance HRSA-supported activities such as BPHC=s Integrated Service Delivery Network initiative for all grantees so as to buttress the positions of grantees in a managed care environment. Often these State-based strategies require HRSA/HCFA support, State legislative action, and/or maximum support of State health departments.

- **$** A State-based strategy could be developed in States without such provisions whereby grantees, collectively and in collaboration with the State health department, demonstrate to the State Medicaid agency the merits of Asix-month lock-in@ provisions in Medicaid managed care, presumptive eligibility, resolution of newborn eligibility determination, and strategies for streamlining eligibility determination.

2.4 Policy Considerations

Recommendations on policy considerations are found to be occasionally internal to HRSA and sometimes interactively between HRSA and State health departments. More often, given the nature of third-party reimbursement, they require collaboration between HRSA and HCFA and may require legislation:

- **$** HRSA might encourage HCFA, in its 1915/1115 waiver approvals, to require States to establish a minimum number of days between Medicaid eligibility determination and managed care enrollment. This should be a result of HRSA=s identifying grantees in States where this is and is not being done in order to target these policy efforts to reduce the access barrier for patients and to enhance grantee reimbursement.

- **$** HRSA, in collaboration with HCFA, should develop recommendations to the HHS Secretary and Congress for removing Medicare/Medicaid/CHIP eligibility barriers for targeted special populations such as the disabled, the homeless, non-English- speaking residents, AIDS/HIV patients, and high-risk pregnant women and their children.

- **$** While HRSA grantees, either individually or collectively, might seek congruency of Medicaid/HRSA case management definitions of services at the State level, as recommended above, it might be more cost effective and have greater impact for HRSA to initiate a Across-bureau@ initiative to define case management services consistently throughout HRSA and congruent with Medicaid service coverage. This should be negotiated with HCFA to ensure that State Medicaid agencies are responsive to revised/clarified case management definitional and coverage issues. State-based case management strategies might then evolve from this Federal initiative. Additionally, HRSA/HCFA case management policy collaborations should include enhancing State

case management options, ensuring State compliance with the Federal Medicaid statute, and consensus on maximizing HRSA grantee patient case management coverage and provider/grantee reimbursement.

- HRSA should approach HCFA to establish a collaborative strategy to alert States to the benefits of Medicaid 1915(c) case management options and to the State=s responsibility for case management under Federal statute. Training for State Medicaid directors and staff could be an outgrowth of this effort. Policy consideration could be given to Aspecial status@ for HRSA grantees= case management services, with HCFA encouraging or requiring States to reimburse for case management services provided by HRSA grantees.

- HRSA should consider developing a taxonomy of traditional public health and personal health services provided by local health departments and working with HCFA to clarify and maximize coverage of these services by Medicare/Medicaid/ CHIP. The results should be communicated to Medicare intermediaries and State Medicaid/CHIP programs as well as to State and local health departments and should form the basis for the State training curriculum recommended above.

- HRSA and its Bureaus could consider requesting (or requiring) grant applicants to provide a third-party Abillability/covered services@ analysis as a part of the justification for a proposed staffing pattern. This is recommended in the same context as the HRSA-initiated (Healthy Start and ORH) Asustainability@ plans; the difference is that it would be done beforehand in the grant application, rather than after the grantee program has been operational for several years.

- HRSA might negotiate with HCFA to develop unique Aincident to@ provisions for HRSA grantees that would maximize reimbursement potential under Medicare/ Medicaid/CHIP for the services of staff that are presently nonreimbursable.

- HRSA should negotiate with HCFA for payment protection policies for its grantees (especially FQHCs and RHCs, which have statutory Awraparound@ language) that would take into account reasonable cost/risk adjustment considerations in Medicare/Medicaid rate setting.

- HRSA could seek enhanced roles and responsibilities with regard to HHS authority to review, approve, and set conditions in State approvals of 1915 and 1115 waivers. For example, HRSA could share review and concurrence authority with HCFA on the terms and conditions of State waivers, managed care contracting language, and establishment of access standards. This might mean that HRSA could negotiate some minimum requirement for contracting between plans and grantees, including defining the nature and

extent of the contracting relationship, to establish minimum access standards that reflect HRSA=s longstanding experience with access problems. HHS Secretarial approval would likely be needed to establish these shared responsibilities between HRSA and HCFA.

- HRSA should clearly establish its policy expectations with its grantees with regard to third-party billing, the grants management infrastructure needed to execute the third-party reimbursement policy, and the systems needed to reassess the ongoing effectiveness of the policy.

- HRSA might consider negotiating the following with HCFA:

  - A reasonable-cost payment methodology and/or risk-adjusted payment methodology under Medicaid/Medicare for HRSA grantees.

  - A Acarve-out@ of special populations, such as HIV/AIDS and HCH patients, from mandatory Medicaid managed care arrangements.

  - Clarification that FQHC physician visits to hospitalized patients are covered FQHC services and therefore billable under Medicaid and Medicare.

  - Collaborative determination of the viability of approaching Congress to legislatively drop the two-year waiting period for HIV/AIDS patients, as was done for end stage renal dialysis patients, or determination of the viability of dropping the two-year waiting period altogether for all disabled beneficiaries.

  - Seeking exemption for its hospital grantees from HCFA=s recent regulations restricting clinics that can bill as OPDs.

  - Adoption of all HRSA grantees as Presumptive Eligibility providers, encouragement of all States to adopt Presumptive Eligibility options, and expansion of Medicaid presumptive eligibility to a broader patient base than pregnant women and their children, that is, to include targeted special populations such as homeless and HIV/AIDS patients**C**which might require legislative authority.

  - Increased monitoring by HCFA of State requirements to make timely payments to providers.

- Increased encouragement (and possibly a requirement, which might require legislative action) of States to adopt the six-month lock-in provision in Medicaid mandatory managed care initiatives.

  Determining the Abest practices@ of States in solving the newborn eligibility determination problem and sharing these solutions with States that are still experiencing difficulty in this regard.

- Clarification of and communication with and monitoring of States regarding the HHS policy on Afirst dollar/last dollar@; this appears to be clear in the case of CHCs and MHCs and assured in the BPHC Atotal budget@ approach and funding methodology and in the case of Ryan White Title II and ADAP (but not Title III) funding, according to the November 25, 1998, memorandum of the HCFA Director of Medicaid to State Medicaid Directors. A copy of this memorandum is presented in Appendix D. Other HRSA grant programs**C**MCH, HS, HCH, ORH**C**appear to be silent on this issue, resulting in the need for HHS policy development (or clarification) in this regard.

- Exploring expansion of Medicaid Presumptive Eligibility opportunities for HRSA grantees and their patients under existing Presumptive Eligibility authority and, if necessary, through enhanced legislative authority.

- Helping State Medicaid programs experiencing newborn enrollment eligibility determination problems to resolve them by identifying and promoting State best practices in this regard.

3. OPERATIONALIZATION OF RECOMMENDATIONS

The following suggestions are offered as potentially useful ways to operationalize the recommendations presented above:

- HRSA should consider developing a national training center to house all of the third-party reimbursement training and TA activities that will be implemented. Such a center could gather and maintain the talent and information necessary for conducting an endeavor of this magnitude.

- HRSA should develop some Ain-house@ capacity regarding third-party reimbursement that would have the responsibility of third-party issue identification and policy analysis and recommendations, HCFA liaison activity, support for Bureaus and grantees, research and

development (e.g. risk-adjusted payment), and providing priorities and direction for the training center.

- $ Videos and video conferencing should be developed for training, to the extent that they are cost effective and the technology is accessible for the grantees.

- $ The development and implementation of the training, TA, and State-based strategies should be carried out collaboratively with the national and statewide associations representing HRSA grantees (such as the National Association of Community Heath Centers, the Association of Maternal and Child Health Programs, the National Council for the Homeless, and the many State primary care and rural health associations) as well as with State health departments and State Medicaid agencies, as appropriate.

- $ Given the nature of much of the recommended training and TA, consideration should always be given to providing assistance through State-based delivery models, especially since State Medicaid and CHIP programs can vary widely and have a significant third-party impact on HRSA grantees.

- $ In light of the generally well-developed organizational structures and functions of State primary care associations and State rural health associations, HRSA should give consideration to the potential usefulness for these State primary care associations to represent all HRSA grantees or for HRSA grantees to form State associations by grantee type and then coalesce, as associations, around common issues. Factors that should be weighed are cost-effectiveness, infrastructure viability, strategic advantages, and comparison with other options for the collaborative, concerted action that will be required at the State level.

- $ HRSA should initiate an assessment of the nature and extent of HCFA=s willingness to collaborate in the training and TA, State-based strategies, and policy development activities recommended in this report. In fact, HCFA collaboration may very well be essential for the successful achievement of many of the recommendations.

- $ HRSA should seek to clarify the HHS policy regarding Afirst dollar/last dollar@ responsibility between HRSA=s grant programs and HCFA=s entitlement programs in order to maximize the use of HRSA grant dollars for uninsured patients and services not covered by third-party reimbursement, as appears to have been the original intent of congressional legislation and HHS policy. This HHS policy clarification should be definitively transmitted to State governments and grantees to ensure that there is adequate, appropriate implementation of Federal policy in this regard.

- $ Given that HRSA often provides grants to large institutional grantees and that third-party revenue generated by the grantee may not be targeted for the grantee program that generated the revenue, HRSA should consider requiring that the third-party revenue generated by the grantee program be returned to the program, specifically as a grant condition that HRSA monitors for compliance.

- $ HRSA should launch a HRSA-wide research and development effort around third-party risk-adjusted payment methodology for targeted populations (e.g. HAB efforts for HIV/AIDS patients). This effort might be explored collaboratively with AHRQ, which has expressed interest in this area.

- $ Because it lacks third-party reimbursement information for many of its grantees, HRSA should consider establishing a minimum third-party reimbursement data set for all of its grantees in order to monitor the effectiveness of its third-party enhancement initiatives and to assess trends in third-party reimbursement and their impact on grantees at the local level over time.

- $ It would be helpful for HRSA=s individual bureaus to share relevant information on their respective policies, procedures, and initiatives regarding third-party reimbursement with one another. Two cases in point are the Bureau of Primary Health Care=s Atotal budget@ grant allocation procedures and the HIV/AIDS Bureau=s exploration of risk adjustment factors in managed care rate setting.

APPENDIX A

REIMBURSEMENT ANALYSIS COMPUTATION

In Chapter II, the project team estimated the reimbursement that could be collected if problems and barriers were eliminated. The information contained in this Appendix details the development of these estimates for each problem. The team met the following guidelines whenever possible:

- $ Use data from the sites visited rather than extrapolated data

- $ Identify all assumptions used in developing the estimates and provide a rationale for their use

- $ Verify the data used with the sites

This reimbursement analysis and the accompanying worksheet matrices, Exhibits A-1 through A-5, reflect data from the site visits only. All of the numerical examples are estimates based on available data and information. In no case are the dollar estimates to be taken as other than very gross estimates. Many of the cells in the exhibits are filled by AUnknown $.@ This means that one or more data elements that were necessary to establish an estimate were unavailable and therefore the estimation could not be completed. Estimates, where made, are all annualized estimates.

The exhibits are all organized in the same manner:

- The first column is the grantee site number.
- The second column is the grantee=s State.
- The third column is the primary grant program for this project.
- The next column starts the 18 issue column, beginning with the issue that is most in control of the grantee (by percentage of control category in the column), with each issue being made up of two columns**C**one wide column displaying the issue at each grantee or the estimate of the reimbursement potential and the narrow column to the right of the main column indicating the grantee control factor, as follows:
  - **C** i = inside the control of the grantee
  - **C** b = within the joint control of both the grantee and another entity
  - **C** e = under control of an entity that is external to the grantee.

Looking at the rows:

- The first two rows at the top relate to the problem addressed in the column.
- The third row indicates which of the seven factor areas the problem resides in.
- The next row indicates how many of the grantees were affected by that issue.
- The remaining rows relate to each of the grantees, as indicated by the numbers in the far left column.

As noted in Chapter II, no single barrier prevented any one of the grantees from maximizing its third-party collections. In most cases, multiple problems or issues were present, preventing or hindering third-party collections. The exhibits display the results found in the 27 site visits:

- Exhibit A-1 indicates the types of problems identified at each of the 27 sites classified by the seven factors in the analysis.

- **$** Exhibit A-2 indicates the estimated dollar amount by subgrantee of revenue (where available data allowed) that might be collected from third parties if the barriers were removed.

- **$** Exhibit A-3 indicates the estimated dollar amount of the third-party revenue that might be collected if barriers that are internal (within the grantees= control) were removed.

- **$** Exhibit A-4 indicates the estimated dollar amount of third-party revenue that might be collected if barriers that are both internal and external to the grantees= control were removed.

- **$** Exhibit A-5 indicates the estimated amount of third-party revenue that might be collected if barriers that are external (outside of the grantees=control) were removed.

16. THIRD-PARTY PROVIDER STATUS

The team identified 12 grantees with problems relating to provider designation. The issues identified included licensing restrictions, lack of recognition (by the grantee) of provider status, managed care organizations= (MCOs=) unwillingness to recognize grantees, and lack of Federally Qualified Health Center (FQHC) status. The team was able to develop potential reimbursement estimates for 6 of the 12 grantees, including homeless centers, Community Health Centers, Migrant Health Centers, and HIV/AIDS grantees.

- **$** **Grantee 2C** This grantee provides services to over 9,000 homeless clients through clinics operated in over 30 homeless shelters. Approximately 5,490 are Medicaid recipients while an additional 3,500+ are without any health insurance coverage. The grantee, while a Federally Qualified Health Center (FQHC), has not used its FQHC status in billing for Medicaid/Medicare services provided through its homeless clinics. The grantee=s FQHC rate is $96.64. The 5,490 Medicaid patients had over 17,500 encounters.

  5,490 X 3.2 average encounters per client X $96.64 FQHC rate = $1,697,771

- **$** **Grantee 3C** As a Section 330 and 340 grantee, this FQHC (with 11 sites) provides a comprehensive array of primary health care and related social and case management services to a wide cross-section of medically underserved persons, including the homeless. This FQHC staffs several of its smaller care sites (largely those based in homeless shelters and elderly housing complexes) with midlevel providers rather than physicians. The Pennsylvania Department of Health (and, therefore, participating HealthChoices MCOs) recognizes only physicians as valid providers for billing purposes. In addition, these smaller care sites operate less than 20 hours per week, as dictated by patient demand. The Pennsylvania Department of Public Welfare will not issue a Medicaid billing number

to any site that is not licensed, and the Department of Health will not license clinics that operate less than 20 hours per week.

The grantee=s FQHC reimbursement is adversely affected by the State licensing and operating hours restrictions. If (1) 10 percent of the grantee=s 22,000 users access services at these smaller, part-time outreach sites, (2) 60 percent of these patients are Medicaid/Medicare recipients, and (3) the average per-member per-month (PMPM) cost is $17, the grantee would lose approximately $269,300 (i.e., 2,200 patients X 60 percent X $17 per member per month X 12 months) in annual Medicaid/Medicare reimbursement from the operation of these sites if current State policies remain in effect.

$ **Grantee 11C** This grantee serves over 1,964 homeless patients through clinics operated in at least four homeless shelters. Approximately 231 are Medicaid and Medicare recipients. While an FQHC, the grantee has not used its FQHC status in billing. The average FQHC rate in the grantee State is $95, and the average number of encounters for homeless patients is 10 per client per year (UDS data).

231 eligible clients X 10 average encounters X $95 FQHC rate = $219,450

$ **Grantee 25C** This grantee operates both an FQHC look-alike and an HIV/AIDS clinic (Title III) that is a Ryan White grantee and the focus of this study=s site visit. While both are Department of Health divisions, they are administered and organized separately. As a result, the Title III clinic does not receive FQHC cost-based reimbursement for covered services rendered to Medicare and Medicaid recipients. Site management reported that the Title III clinic has an active caseload of 1,100 patients, many of whom are Medicaid or Medicare eligible but for whom the Title III clinic is not receiving FQHC reimbursement. If the Title III clinic were reorganized as operating function of the Department of Health=s FQHC look-alike, this grantee could receive an estimated $415,800 in additional FQHC Medicaid and Medicare reimbursement annually assuming 50 percent of its patients are Medicaid or Medicare eligible (i.e., 1,100 active patients X five visits annually X 50 percent Medicaid and Medicare patients X $151 per visit).

2. PATIENT ELIGIBILITY

The study team identified 19 grantees under all types of HRSA programs with problems relating to eligibility. They included lack of outstationed eligibility workers, lack of appropriate forms, lack of coordination, eligibility and enrollment procedures for dual eligibles, a 24-month waiting period for Medicare eligibility, undocumented residents, complicated State eligibility procedures and requirements, and no billing during the eligibility determination window. The study team was able to develop estimates for 3 of the 19 grantees, including homeless and HIV/AIDS grantees.

$ **Grantee 1C** This grantee is a Ryan White Care Act Title III grantee providing services in an urban area to patients currently identified as Auninsured.@ These Auninsured@ patients comprise approximately 18 percent of grantee=s client base. Some of these patients may actually be eligible for insurance coverage. If an additional 2 percent of their client base were found to be eligible for Medicaid or Medicare, this would result in an additional 20 clients having insurance coverage. At the average annual third-party reimbursement rate of $1,683, these additional 20 clients, if covered, would generate $33,658 in third-party revenue.

The grantee generates approximately $1,683 in third-party revenue for each of its clients each year. At present, the grantee is not taking advantage of the fee-for-service billing opportunity available during the 45-day Aeligibility window@ for its new clients. Applying the average daily revenue for each of the 325 new clients that the grantee began to serve in the past year over the 45-day Aeligibility window@ results in: 325 new clients X $1,683 average revenue per year X (45 days/360 days) = $67,278 per year of possible additional third-party revenue.

$ **Grantee 3C** This grantee operates a homeless project averaging 9,000 visits per year, with 61 percent of those visits being Medicaid client visits. The grantee is also an FQHC. It can be assumed that 25 percent of those Medicaid clients were new each year and the grantee is not currently billing for these clients during the State=s 45-day eligibility window. Since the grantee is a homeless services grantee, this amount of Anew@ clients is a reasonable estimate. As an estimate of revenue potential, the grantee=s FQHC rate of $96.73 was used.

9,000 X 61 percent X 25 percent X $96.73 = $132,762

$ **Grantee 11C** This grantee provides care to 1,707 homeless clients that are not covered by Medicare or Medicaid. All the clients served by this grantee have incomes below 100 percent of the Federal poverty level and may be qualified for either Medicare or Medicaid with more vigorous eligibility assistance by the grantee.

1,707 clients X 10 encounters per client X $95 State average FQHC rate = $1,621,650

3. COVERED SERVICES

The project team identified 22 grantees with problems relating to covered services. They included lack of staff certification (seven grantees), deficient waiver and case management coverage, lost opportunities under home and community-based (HCB) services waivers, services not included in existing HCB services

waivers, not being recognized as a waiver provider for high-risk pregnant women and children, not reimbursing for targeted case management and for children with an elevated blood lead level (impacting 22 of 27 sites), services not reimbursed (impacting 7 of 27 sites), and nonreimbursable staff (impacting 6 of 27 sites). The study team was able to develop estimates for 4 of the 22 grantees.

3.1 Lack of Staff Certification

We were unable to develop estimates for this area, and we therefore integrated the available data with data for the deficient waiver/case management problem areas (see 3.2 below). Staff certification problems were largely in the area of case management.

3.2 Deficient Waiver/Case Management

Grantee-related problems in the deficient waiver/case management area are presented below.

3.2.1 Maternal and Child Health Programs

Grantee 9 is using both Title V and State general funds to pay for services being provided to children with special health needs. Pennsylvania=s Department of Public Welfare, the Single State Medicaid Agency, has a 1915(c) waiver to provide services to these children. The waiver pays for case management services, private duty nursing, and medically necessary equipment. The Department of Health (DOH) is paying for respite, home health, and other services to families included in the waiver. All of the services that DOH provides to the families included in the waiver should be included as covered services under the waiver. The DOH is currently spending approximately $944,000 for respite or other services that could be included in the existing waiver. Assuming the same level of services, the DOH could enhance Medicaid Federal revenue by including respite and other services currently being provided to children with special health care needs in the existing waiver, increasing revenue by $508,060[9] (this is a statewide figure).

3.2.2 Enhanced Prenatal Care/Children with Special Health Care Needs

Michigan has an approved 1915(b) waiver for high-risk pregnant women. This waiver was established prior to its managed care waiver and is still operational. The Healthy Beginnings Plus (HB+) waiver includes case management services. The State contracts with providers throughout the State to provide HB+ services. Local health departments and Healthy Start projects are not recognized as providers of HB+ services.[10] Grantees 4, 6, 8, and 9 have been providing case management services to women eligible for and/or enrolled in HB+ but they have not been able to contract with the State to provide the services and obtain reimbursement from Medicaid. Grantee 9 has been negotiating with the local MCO for several years but has been unable to come to any agreement.

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[1]Pennsylvania=s Federal Medical Assistance Percentage rate is 53.82%.

[2]HB+ providers are limited to physicians, Midwives, Rural Health Clinics, FQHCs, hospitals, and outpatient departments.

If these projects were able to resolve their contracting problems with the State, they could bill for these services. The provider receives $204 for perinatal support services for women with a Anormal@ pregnancy for the first two trimesters and $456 for perinatal support for high-risk women for the same period. In addition, payment for the third trimester, including a normal delivery, is $1,386 (an average of $900 for delivery and $456 for prenatal care), and for a high-risk delivery it is $1,576 (an average of $950 for delivery and $626 for prenatal care). The following provides possible HB+ reimbursement estimates for two grantees.

$ **Grantee 7C** This project served 1,028 pregnant women in 1998. The following assumptions were used to estimate the level of billing that this project could generate: 40 percent of the patients are classified as high risk**C** 411 high-risk and 617 normal pregnancies. Excluding third trimester and delivery, this project could bill:

	High risk: 411 X $1,082 =	$444,702
Normal:	617 X $ 690 =	$425,730
	Total	**$870,432**

4. Grantee 13**C** Prior to the establishment of the Michigan Medicaid managed care program, the Department of Community Health provided enhanced services to high-risk pregnant women and their children through the Maternal Support Services (MSS) and Infant Support Services (ISS) programs. Both programs were incorporated into the State=s managed care program. In addition, the county operates the Enhanced Maternal Support Services (EMSS) program (for high-risk substance-abusing pregnant women). The Maternal and Infant Health Advocacy Services (MIHAS) program provides supports to at-risk pregnant women who are Medicaid eligible. Qualified health providers are now required to provide MSS and ISS services. Local health departments and Healthy Start projects are providing these services, especially MSS, to women enrolled in the Medicaid program but are not being reimbursed. The plans are unwilling to contract with the agencies, yet they have referred women to them. In 1998, the grantee provided MSS services to 222 pregnant women, EMSS services to 21, and MIHAS services to 346.

   All children with special health care needs and their families receive case management services. If the child lives in one of the five counties in the State=s managed care program, then the case management services must be provided by the managed care organization in that area. For the remainder of the State, case management services are provided by the local health departments. The grantee provided case management services to 656 children and their families in 1998. An additional 112 children received diagnostic evaluations. At least 50 percent of these children and their families will be eligible for services.

Assuming that Michigan would reimburse at the same rate as Pennsylvania=s HB+ and that the case manager is paid $300 per family, then:

MSS:	222 X $ 1,082	=	$240,205
EMSS:	21 X $ 1,082	=	$ 22,722
MIHAS:	346 X $ 690	=	$238,740
656 families X $ 300		=	$196,800
56 new families X $300		=	$ 16,800
Total			**$715,267**

3.2.3 Targeted Case Management Services

In its State plan, Pennsylvania has included targeted case management services for eligible recipients with mental retardation, adults with severe and persistent mental illness, children with severe mental illness, and AIDS or symptomatic HIV patients. The State has established a certification procedure for case managers. The HIV/Title III grantees in Pennsylvania=s large urban areas provide case management services to eligible clients, but neither project is currently billing or obtaining reimbursement for these services. The case managers are paid on an encounter basis, with a maximum case load of 25 clients per case manager. While the reimbursement methodology used by Pennsylvania is not clear (due to the multitude of parties involved), most States reimburse case managers either by the amount of time devoted per client (15 minutes equals one encounter) or on a monthly per capita basis for one or more encounters. Two options for estimating reimbursement are presented in the sections that follow.

Based on data from several States using a targeted case management approach, the case manager is paid an average of $200 per client for each client having an encounter that month. If a case manager is assigned 25 clients, it will be serving approximately 20 per month. The case manager would then be able to bill $ 4,000 per month.

- **C** **Grantee 4C** This project has 2.5 full-time equivalent (FTE) staff currently providing case management services: 2.5 FTEs X $4,000 per month X 12 months = $120,000 per year. (The project does not provide case management services to all of its clients, so those data could not be used for this estimate.)

- **$** **Grantee 1C** This project has 862 eligible clients and has the potential for effectively utilizing 34 FTE case managers to serve its patients: 34 FTEs X $4,000 per month X 12 months = $1,632,000 per year.

3.2.4 Lead Case Management Services

Grantees 6 and 8 are providing screening, environmental assessment, and case management services to families with children having an elevated blood lead level (15 micrograms per deciliter or higher). The local

health departments are the agencies responsible for providing both the environmental assessments and the case management services. The State is reimbursing both agencies only for the environmental assessment, however. The State Medicaid agencies have been explicitly directed by HCFA (October 22, 1999) to reimburse providers for screening, environmental assessment, and case management services. This directive is presented as Appendix C.

Grantee 6 had 81 clients and grantee 8 had an estimated 250 with an elevated blood lead level. All will need some case management services**C**the higher the blood lead level, the more intensive the case management required. Assuming a per capita payment of $300 per child per year for grantee case management services, 81 X $300 = $24,300 in potential billing for grantee 6, and for grantee 8, 250 X 300 = $15,000 in potential billing..

Grantee 20 is providing services to over 800 children with an elevated blood lead level. The grantee does lead screening, provides limited environmental lead assessment, and provides case management services to all children with an elevated blood lead level. It receives no reimbursement for providing any of these services.

Assuming that this grantee receives reimbursement equal to that offered by Pennsylvania for identical services, then:

800 environmental assessments X $279.50	=	$223,600
800 children needing case management X $ 300.00	=	$240,000

Grantees 2, 3, 5, 11, 10, 15, 19, 21, and 23 provide screening, environmental assessment, and case management services to children with an elevated blood lead level.

$	Grantee 2:		
	34 environmental assessments X $279.50	=	$ 9,503
	34 children needing case management X $300.00	=	$ 10,200
			$ 19,703
3.	Grantee 3:		
	108 environmental assessments X $279.50	=	$ 30,186
	108 children needing case management X $300.00	=	$ 32,400
			$ 62,586
4.	Grantee 5:		
	48 environmental assessments X $279.50	=	$ 13,416
	48 children needing case management X $300.00	=	$ 14,400
			$ 27,816
$	Grantee 10:		
	103 environmental assessments X $279.50	=	$ 28,789
	103 children needing case management X $300.00	=	$ 30,900

			$ 59,689
$	Grantee 11:		
	4 environmental assessments X $279.50	=	$ 1,118
	4 children needing case management X $300.00	=	$ 1,200
			$ 2,318
Grantee 15:			
	181 environmental assessments X $279.50	=	$ 50,589
	181 children needing case management X $300.00	=	$ 54,300
			$104,890
5.	Grantee 19:		
	73 environmental assessments X $279.50	=	$ 20,404
	73 children needing case management X $300.00	=	$ 21,900
			$ 42,304
2.	Grantee 21:		
	31 environmental assessmentsX $279.50	=	$ 8,665
	31 children needing case management X $300.00	=	$ 9,300
			$ 17,965
$	Grantee 23:		
	36 environmental assessments x $279.50	=	$ 10,062
	36 children needing case management x $300.00	=	$ 10,800
			$ 20,862

3.3 Nonreimbursable Staff

Grantee 2 provides services to 36 homeless clients who are enrolled with one of the Medicaid managed care MCOs. Due to the grantee=s inability to certify staff at the clinic according to the MCO=s standards, the grantee does not have a contract with the MCO. The total number of encounters for the homeless clients was 398, and the grantee=s FQHC rate is $96.64 per encounter.

398 encounters X $96.64 = $38,462

4. RATES AND COSTS

The study team identified 21 grantees with problems relating to rates and costs. They included deficient rates, inadequate cost and charge setting, and deficient FQHC/RHC wraparound payments. The study team was able to develop estimates for 10 of the 25 grantees, including Ryan White Title III clinics, MCH subgrantees, and Community Health Centers.

4.1 Deficient Rates

Several HIV/AIDS Title III grantees identified insufficient Medicaid managed care capitation rates as a serious problem given the high cost of providing care to HIV/AIDS patients. Estimates of the additional

reimbursement that might be obtained by individual HIV/AIDS Title III grantees if risk-adjusted Medicaid managed care capitation rates were adopted by State Medicaid programs is presented in Exhibits A-1 through A-5.

In States that have a risk-adjusted capitation strategy in their managed care programs, rates are set at highly variable amounts within public assistance categories and age/gender subgroups. To estimate the average capitation rates currently used nationally, rates estimated in a study conducted by the Urban Institute=s Assessing the New Federalism Project were applied. These rates were adjusted for a variety of factors to achieve average national rates for several age and gender groupings. For the purposes of this project, the study team selected the 50th and 100th percentile rates for women and men ages 45 to 64 to create a midpoint and a ceiling for current rates. The age group used is slightly older than the average age of persons with AIDS at entry into Medicaid enrollment via the Supplemental Security Income (SSI) program. The age group used, however, is likely to be reflective of disabled individuals of both genders who enroll in SSI.

To estimate what a grantee might gain in revenue through an AIDS risk-adjusted rate, a comparison of the PMPM difference between the New York AIDS risk-adjusted rates and the national average capitation rates was developed. Based on the data used, currently a Medicaid managed care plan receives an average of between $194.78 and $327.54 PMPM for managed care members between 45 and 64 years of age. Within an enhanced rate structure for members with AIDS, a plan would receive between $973.36 and $2,483.16 PMPM.

Deficient rates were identified by the Ryan White Title III Act grantees visited as a major problems in all three States. In Texas, Pennsylvania, and Michigan, enhanced risk-adjusted HIV/AIDS rates have not been adopted by the State Medicaid programs. While Pennsylvania has adopted an inpatient risk pool arrangement, the grantees did not report benefitting from this strategy. The HIV grantees visited shared experiences observed throughout the United States. Most State Medicaid programs have not adopted HIV/AIDS enhanced capitation rates.

While a few exceptions exist, such as California, Maryland, and New York, most States continue to use the rate structures generated by standard methodologies that do not adjust for clinical case-mix. The HRSA HIV/AIDS Bureau (HAB) has closely examined this situation and created several projects to support HIV/AIDS risk-adjusted rate/methods development. HAB staff have also worked closely with HCFA staff to support State Medicaid programs in their efforts to undertake HIV/AIDS risk adjustment.

Despite the above efforts, the HAB grantees visited continue to participate in Medicaid managed care programs that do not risk-adjust for HIV/AIDS patients. As a result, MCOs receive standard rates based only on public assistance category, age, gender, and geographic service area. For Medicaid recipients with HIV/AIDS enrolled in TANF, those rates are likely to be at least $1,500 to $2,000 less than the actual cost to provide the nationally recognized standard of HIV care. While SSI rates are slightly higher, they are likely to be at least $1,000 to $1,500 less than the cost of care for HIV/AIDS patients.

Managed care plans operating in communities with high rates of HIV have been observed to address inadequate rates for HIV/AIDS care in several ways. Managed care plans may not be interested in contracting with HIV clinical programs, such as the grantees visited. They may also offer extremely low subcapitation rates to HIV services providers. Alternatively, they may contract with providers that are willing to accept low subcontract payments. Several of the grantees visited had accepted low payments because they had other sources of revenue, such as grants. This again reflects the cost shift from Medicaid to grant dollars. Several grantees also expressed concern that their patients might be treated by inexperienced providers if the grantee were to stop contracting with plans.

4.2 Deficient FQHC/RHC Wraparound Payments and Inadequate Cost/Charge Setting

FQHCs and RHCs have Federal statutory rights to reasonable cost reimbursement in Medicaid managed care arrangements, whereby the State pays the FQHC/RHC a wraparound payment, the difference between what the plan pays the FQHC/RHC and the FQHC/RHC=s reasonable cost. State implementation and declining Federal statutory protections have compromised the A100 percent of reasonable cost@ principle, resulting in deficient wraparound payments.

Inadequate cost/charge setting reflects the phenomenon that the grantee does not develop its charges based upon its costs, resulting in a grantee charge schedule that is not established to cover its costs from third-party payors.

- **Grantee 10C** This grantee is an FQHC that provides a comprehensive array of primary health care and related social and case management services. Michigan=s FQHC reimbursement policy calls for annual declines over the next three years. At present, the grantee receives 100-percent cost-based reimbursement for services rendered to Medicaid recipients. However, the grantee expects to lose $3 per visit next year and an additional $8 per visit the following year. Therefore, the extent to which expected Medicaid reimbursement losses can be curbed depends on the grantee=s ability to decrease its current per-visit cost of $119 and/or renegotiate current payment policies with the State. If this issue is resolved by either means, the grantee stands to avoid losing approximately $62,200 in Medicaid reimbursement next year (i.e., 8,287 reported Medicaid users X 2.5 visits per year X $3.00) and more than $165,700 the following year (i.e., 8.287 reported Medicaid users X 2.5 visits per year X $8.00), for a total of approximately $227,900 in enhanced Medicaid reimbursement over the next two years.

- **Grantee 24C** As a Maternal and Child Health subgrantee in the State of Texas, this grantee organization operates 39 clinic sites that provide MCH services to pregnant women and their children who reside in 50 South Texas counties. The Texas Maternal and Child Health program allows subgrantees such as this one to bill for MCH services up to an annually defined grant amount. Subgrantees continue to bill even after they have exceeded their grant amount, in case they are able to get reimbursed beyond their maximum if other

MCH subgrantees do not utilize or bill for their maximum amount. The grantee does not keep records in a way that would allow it to distinguish the cost of providing MCH services from that of other outpatient services.

Thus, the amount of lost reimbursement cannot be accurately measured. However, the grantee estimates that it receives only 60 percent of each dollar that it bills the State for MCH services. Assuming this ratio is reasonably accurate and also applies to the other 38 grantee care sites, and assuming that these sites collectively render 50,000 MCH visits annually and that each visit costs $50, the cumulative amount of loss reimbursement would be $1 million. These assumptions seem quite conservative given the size of the grantee organization, the vast geographic area and number of patients it serves, and the cost of services provided from a hospital-based clinic. Therefore, it seems reasonable that the grantee would benefit from a more accurate accounting of the cost of providing MCH services and a renegotiation with the State of Texas to ensure that it receives full cost reimbursement for the provision of such services.

- **Grantee 23C** This grantee is an FQHC that provides a broad range of covered preventive and primary health care services. The State of Texas limits reimbursement for FQHC administrative costs at 30 percent of overall costs. The grantee has exceeded this cost ceiling by approximately $135,000 in each of the past three years. These costs were disallowed in part because the grantee inappropriately classified patient care costs as administrative expenses. As a result, the grantee lost up to $68,850 in Medicaid reimbursement (i.e., $135,000 annually X 3 years X 17 percent Medicaid patients).

- **Grantee 19C** This health center=s subsidized outreach workers (Apromotoras@) have not been included in its cost-based reimbursement calculations. While the promotoras are not fully paid for by the grantee, there are costs associated with their work for the center. The staff at the clinics indicated that the annual cost to the center for each subsidized outreach worker is $10,375. Therefore, the potential reimbursement that could be obtained for the promotoras is $20,750 (two subsidized outreach workers X $10,375).

5. BILLING SYSTEMS

Billing deficiencies was one of the most pervasive problems encountered during the grantee site visits. It is also one of the most easily correctable difficulties. The study team identified 23 grantees with problems relating to their billing system. These included inadequate billing, lack of billing, and inadequate accounting and recordkeeping. The study team was able to develop estimates for seven of the grantees visited (representative of all HRSA programs).

- **Grantee 1C** The study team estimated the potential for third party reimbursement by assuming a 5- to 10-percent improvement in billing, equating to approximately $10,350 in additional reimbursement.

- **Grantee 10C** The study team estimated that just a 1-percent improvement in billing performance could result in a minimal $49,618 increase in third-party reimbursement.

- **Grantee 11C** An $85,827 increase in third-party reimbursement was estimated by multiplying the grantee=s estimated volume of Medicaid visits times the FQHC rate for a similar grantee. This grantee is an FQHC that has not embraced its FQHC status for reimbursement purposes.

- **Grantee 26C** This Healthy Start project provides transportation services to pregnant and new mothers. By multiplying the number of trips for Medicaid-eligible clients (15,700) by the average length of a trip (20 miles) and multiplying the result by the rate per mile ($0.28), the study team estimated that $87,920 in additional third-party reimbursement could be collected. This grantee was unaware that transportation services are covered under Medicaid and carved out of the State=s managed care plan and thus could be billed separately.

- **Grantee 27C** This grantee operates two rural health outreach clinics. The site visit revealed that the grantee has a poor grasp of the financial operations of these clinics and has not fully embraced its Rural Health Clinic status to secure reasonable cost reimbursement. Thus, minimal billings were being made to third-party payers. In 1999, these part-time clinics collectively provided preventive and primary health care services to approximately 1,600 patients. Approximately 644 (i.e., 40 percent) of these patients were Medicare and Medicaid recipients. Assuming an average annual visit rate of 2.5 visits per patient and an conservatively estimated visit cost of $50, this grantee could receive an estimated $80,500 in additional Medicaid and Medicare reimbursement annually (i.e., 644 Medicare/Medicaid patients X 2.5 visits annually X $50.00 per visit).

6. MANAGED CARE IMPACT

The team identified 18 grantees with problems relating to deficient managed care contracting. The primary problem facing HRSA grantees is the unwillingness of Medicaid managed care organizations to recognize them as providers and to reimburse them for services provided. The study team collected enough information from three of the grantees to be able to develop estimates of potential third-party reimbursements. These calculations are incorporated under the Third-Party Provider Status and Eligibility sections above, given the multiple dimensions of these problems and to ensure no duplication of the calculations.

7. OVERARCHING ISSUES

Most of the problems and barriers identified during the site visits could be rectified either by the grantee or with assistance from HRSA. There were, however, problems that were policy in nature and not so easily rectified. For many of these Federal and/or State policies need to be established or changed. Some can only be addressed jointly by HRSA and HCFA, with the States assisting in some cases. The problems identified include the need for special recognition for both the homeless and migrants, appropriate use of State and local government general funds for Federal matching, and lack of support for use of administrative case management billing options on the part of State Medicaid agencies. It should be noted that dollar estimates in this area are for the grantee organization, not necessarily exclusively for the grantee program.

7.1 Unfavorable Policy, Regulations, and Legislation

Grantee 5, an FQHC, reported that a HCFA Medicare policy prohibited it from getting reimbursed for physician visits when the patient was hospitalized. The grantee estimated the policy resulted in a $100,000 loss to the FQHC.

Grantee 24, a hospital that is an MCH subgrantee, reported that recently published HCFA regulations restrict hospital off-site clinics= recognition as outpatient treatments for payment purposes and estimated that these regulations would cost the hospital $5 million.

Other quantifications in this factor area are included under other problem areas, such as third-party provider designation and deficient rate negotiations, in order not to duplicate quantification.

7.2 Administrative Case Management

State Medicaid agencies may draw 50-percent Federal matching dollars for the performance of administrative case management functions that they directly provide or contract for. These opportunities were not fully explored by States and grantees.

- **Grantee 13C** There are eight programs operated by the grantee that are relying on county funding but are not being used by the State for additional matching. The total payroll for the eight programs is $356,040. From the grantee=s annual report, it appears that approximately 56 percent of the individuals they served are Medicaid eligible. A sample claim for the grantee, assuming no limiting conditions on the part of the State Medicaid program, would be:

  $ 356,040 X 56 percent (Medicaid eligible) = $199,382 X 55.11 (FMAP rate) = $109,860

- **Grantees 20 and 25C** These grantees have been submitting administrative case management claims. Grantee 25 started to submit claims in 1992, with an average claim of $1.2 million. Grantee 20 started in 1997, with an average claim of $370,000. Neither agency has received any reimbursement from the State. Due to the study team=s intervention, the Texas Department of Health (TDH) is reviewing its procedures. TDH has completed audits of both of the grantees. Grantee 20 will be receiving approximately $350,000 out of $370,000 claimed for 1997. Grantee 25, due to lack of data on the number of Medicaid clients seen during the reporting period, will be receiving only $200,000 out of a $1.2 million claim. Grantee 25's problems are correctable.

7.3 Disproportionate Share Hospital Reimbursement

While the impact of DSH reimbursement losses to grantees or subgrantees that are DSH hospitals was not able to be quantified in this project, it should be noted that these grantee organizations are starting to experience significant DSH losses that eventually will impact the grantee program, particularly to the extent that the grantee program=s patients are uninsured by third parties.

APPENDIX B

MEDICAID CASE MANAGEMENT MATRIX

Type of Case Management	Definition or Description of services	Applications, Circumstances
Optional targeted case management Social Security (SS) 1915(g)(2)	Broad definition of services; case management here means services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational and other services. No "statewideness" or compar-ability of amount, duration or scope of services requirements apply.	Part of the 1986 COBRA amendment to the Social Security Act. Prior to this, case management could not be billed as a separate service. States may target (and thereby restrict or limit to) specific populations. FMAP rate applies.
Administrative Case ManagementC A function necessary for the proper and efficient operation of the State's Medicaid plan pursuant to SS 1903(a)	Case management here is viewed as a function (rather than a service) intended to facilitate the operation of the State's Medicaid plan. Activities such as utilization review, prior authorization of services and nursing home pread-mission would be included. Some functions may directly benefit patients.	May be some overlap of services with other types of case management, e.g., arranging transportation of a patient. Outreach activities could be included here rather than under targeted services. Reimbursement rate is at the lower, administrative FFP rate (usually 50%).
EPSDTC Case management has always been a part of the EPSDT program. SS 1905(a)	States must provide services deemed medically necessary by EPSDT screening. Services may be provided by existing provider or another agency.	Generally broad services available here (since 1986 amendment, SS 1915(g) definition used). However, they must be medically necessary.
Waivers: 1915(b) 1915(c)	Balanced Budget Act of 1997 added primary care case management as an optional service to SS 1905(a). Typically this includes referrals. (Clinical case management only.) Home and community-based services waivers. Case manage-ment services provided under a plan of care, subject to State Medicaid approval. State selects group of individuals to whom case management services will be offered.	1915(b) waivers restrict freedom of choice of providers. Not the case for 1915(c). FMAP rate applies to both.
Component of service	Historically available where a necessary part of another service, e.g., case management under FQHC services.	No separate reimbursement for case management; reimbursement added to other service.

APPENDIX C

2. STATE BACKGROUNDCPENNSYLVANIA

This section provides an overview of the third-party payor programs operational in the State of Pennsylvania.

1.1 The Medicaid Picture

The State of Pennsylvania has a population of approximately 12 million individuals. Medicaid enrollment in the State is approximately 1.2 million; of these, 68 percent, or about 900,000 individuals, are enrolled in a managed care organization, in the form of either a fully capitated health maintenance organization (HMO) or a primary care case management (PCCM) program. About 10 percent of the population are uninsured. Pennsylvania=s current Medicaid match rate is 54 percent. Total Medicaid expenditures (State and Federal funds) in Pennsylvania for Fiscal Year (FY) 1998 were approximately $8.849 billion. DSH funds sent to hospitals serving uninsured and Medicaid-eligible individuals in the State for 1998 totaled $546 million, or a comparatively low 6.2 percent of total Medicaid expenditures in the State.

1.2 The HRSA Grants Picture

All of HRSA=s grant programs are found throughout urban and rural Pennsyvania. The sections that follow present an overview of the HRSA grants programs active in Pennsylvania.

1.2.1 The Maternal and Child Health Program

The State Title V block grant for its Maternal and Child Health program is approximately $26 million. The maintenance-of-effort requirement for the State is $20,065,574.58. In FY 1999 the State appropriated $44,369,000 for MCH activities. The State thus has an overmatch of $24 million that can be used for additional State Title XIX matching. In FY 1999 there were six Healthy Start grantees in Pennsylvania (two in Philadelphia; one each in Chester, Pittsburgh, Uniontown, and West Chester).

1.2.2 HIV/AIDS Program

Philadelphia is the only Ryan White CARE Act Title I city in Pennsylvania. Title II of the Ryan White CARE Act supports services to persons with HIV/AIDS, including the provision of medical and social services, case management, and drug assistance. In 1998, the State=s Title II budget was $16,937,811, including $9,426,543 in State matching funds. The required State match is $8,468,906, leaving an overmatch of $957,637. There are six Title III grantees in the State: three in Philadelphia and one each in Allentown, Pittsburgh, and York. Total State funding under the Ryan White CARE Act in FY 1999 was $47,260,484.

The State has elected to include targeted case management services for individuals with AIDS or symptomatic HIV infection in its plan. Both Title II and Medicaid cover case management services provided by a State-certified case manager. In the Pittsburgh area, both Title II and Medicaid case management services are offered through one provider.

1.2.3 Primary Care (Including the Bureau of Primary Health Care and the Office of Rural Health Policy

In FY 1999, Pennsylvania received $32,913,004 from HRSA to support primary care centers and $413,470 for rural health activities. The Bureau of Primary Health Care is supporting 30 primary care centers in Pennsylvania and four homeless projects (two in Pittsburgh and one each in Erie and Wilkes-Barre). The Office of Rural Health Policy supported one project in Lock Haven.

1.3 The Medicaid Managed Care/Waivers Picture

Pennsylvania has four 1915(b) managed care waivers in place. One is for Philadelphia and its surrounding counties (HealthChoices Southeast, consisting of several HMO plans); one is for Pittsburgh and its surrounding counties (HealthChoices Southwest, also consisting of several HMO plans). The third waiver covers Lancaster and the surrounding counties and provides PCCM. The fourth 1915(b) waiver covers families and children outside Philadelphia and Pittsburgh through a PCCM program referred to as the Family Care Network.

Prior to the start of the HealthChoices program, the State Department of Health operated the Healthy Beginnings project. Healthy Beginnings provided case management, nutritional counseling, and other services to high-risk pregnant women. This program was later incorporated into the HealthChoices program. It is not clear whether the Healthy Beginnings mandate was explicitly included in the contract between the managed care organization (MCO) and the Department of Public Welfare. In 1985, Pennsylvania received a 1915(b) waiver for high-risk pregnant women. HCFA still lists this as an Aactive@ waiver. HealthChoices Southeast serves 35 percent of the State=s Medicaid population; Health Choices Southwest covers an another 22 percent. Managed care plans are reluctant to enter markets outside the major cities, and fee-for-service medical care continues to dominate in the more rural, less populous areas of the State.

1.4 Home and Community-Based Services Waivers

In addition to 1915(b) waiver and fee-for-service programs, Pennsylvania has nine home and community-based services (HCB) waiver programs (1915(c), including one for HIV/AIDS that provides homemaking services, special equipment, nutritional supplements, and consultation. There is also a model waiver for technology-dependent individuals under 21 with chronic debilitating medical conditions resulting from premature birth or congenital and/or genetic anomalies. The State provides similar services, using State general assistance funds, to children with special health care needs and provides respite services to children included in the model waiver. The project team was unable to discern why this redundancy exists.

1.5 Unique State Considerations

Pennsylvania provides Medicaid-funded and State-funded general assistance to eligible individuals. Medical assistance benefits are organized by benefit package. Benefit packages 1 and 2 provide the most extensive benefits. Package 1 is for categorically needy individuals under 21 years of age; most in this category qualify for Federal Temporary Assistance for Needy Families (TANF) funds. Package 2 recipients are categorically needy elderly or disabled, usually receiving Supplemental Security Income (SSI) funds. Benefit packages 3 and 4 are State assistance funds. Benefits in packages 3 and 4 limit the number of doctor=s visits and the amount of prescription drugs. Pregnant women applying for medical assistance are presumed to be eligible for Medicaid benefits pending review of their application. Any newborn whose mother is on medical assistance may receive care for at least 12 months after birth. Case management services in Pennsylvania are available to certain targeted groups: eligible recipients with mental retardation, adults with severe and persistent mental illness, children with a severe mental illness or emotional disturbance, and AIDS or symptomatic HIV patients.

Certain structural and jurisdictional matters are worth noting. The Medicaid agency in Pennsylvania operates within the Department of Public Welfare, rather than within the Health Department, as is the case in many States. Also, some local (city and county) health departments are not permitted to bill Medicaid directly for services but must submit bills to the Department of Health, which in turn bills Medicaid through its own billing number. Many services provided by local health departments are not reimbursable under State Medicaid regulations. This could be a cause or an effect of not being able to bill directly. Few local health departments serve as providers under managed care plans. While States are permitted under Medicaid to match Federal administrative case management funds, Pennsylvania is not billing for administrative case management services.

3. STATE BACKGROUNDCMICHIGAN

This section provides an overview of the third-party payment programs operational in the State of Michigan.

2.1 The Medicaid Picture

Michigan has a population of approximately 9.6 million individuals. Medicaid enrollment in the State is approximately 1.2 million, of whom 750,000 are enrolled in managed care plans. As of the spring of 1999, Michigan discontinued its PCCM programs; managed care in the State is now provided only through fully capitated HMOs. About 11.5 percent of the population are uninsured. Michigan=s Federal Medicaid match rate is 55 percent. Total Medicaid expenditures (State and Federal funds) in Michigan for Fiscal Year 1998 were $6.218 billion. DSH funds sent to hospitals serving uninsured and Medicaid-eligible individuals in the State for Fiscal Year 1998 were $319 million, or a comparatively low 5.1 percent of total Medicaid expenditures in the State.

2.2 The HRSA Grants Picture

The full array of HRSA programs are active in the State of Michigan. These programs are described briefly in the sections that follow.

2.2.1 Maternal and Child Health

The Michigan Department of Community Health (MDCH) operates traditional public health programs and is the State=s Medicaid agency. Title V=s maintenance-of-effort requirement for Michigan is $13,507,900. The State has appropriated $35,914,800 for FY 2000 for Title V activities, which leaves an overmatch of $22,406,900. It appears that the State is using these dollars for matching additional Medicaid support.

MDCH provides grants to the local health departments that comprise both Federal and State funds. County general funds allocated to local health departments are being used by the State to match Federal funds. When county funds are used for Medicaid matching purposes, the county receives the Federal share. In FY 1999, there were five Healthy Start grantees in Michigan, one each in Detroit, Flint, Kalamazoo, Saginaw, and Sault Ste. Marie.

2.2.2 HIV/AIDS

Detroit is the only Ryan White CARE Act Title I city in Michigan. There are four Title III grantees in Michigan, two in Detroit and one each in Ann Arbor and Grand Rapids. Funding under the Ryan White CARE Act in FY 1999 was $20,927,888.

2.2.3 Primary Care (Including BPHC and the Office of Rural Health Policy)

In FY 1999, Michigan received $24,521,660 from HRSA to support primary care centers and $1,240,044 for rural health activities. The Bureau of Primary Health Care is supporting 31 primary care centers in Michigan and seven homeless projects (one each in Algonac, Battle Creek, Detroit, Flint, Grand Rapids, Kalamazoo, and Lansing). The Office of Rural Health supported three rural health outreach projects (one each in Houghton, Monroe, and West Branch).

2.3 The Medicaid Managed Care Waivers Picture

Michigan is under one statewide 1915(b) waiver. Notwithstanding this, certain populations in certain situations have a choice of managed care or fee-for-service (e.g., members of Native American tribes, individuals eligible for Michigan=s Crippled Children=s Program, nursing home residents, dual-eligible Medicare enrollees, and individuals living in a county with only one plan). Michigan has embarked on a statewide effort to have HMOs licensed as full-risk HMOs under the State Department of Insurance (rather than partial risk, where the Medicaid agency pays claims and then seeks reimbursement from the HMO). If a plan does not move fast enough in the direction of Afull risk,@ the State may freeze its enrollment.

2.4 Home and Community-Based Services Waivers

The State has developed a managed care program for children with special health care needs, The Children=s Specialty and Children=s Comprehensive Health Care Plan, sometimes referred to as the Special Health Plan (SHP). Eight counties currently participate in the program. The State plans to have all counties in the program by 2001.

SHP enrollment is voluntary; eligibility is determined by the State and is based on the medical diagnosis, the severity and chronicity of the child=s condition, and the need for a subspecialist. Certain individuals over 21 years may also qualify for the program. Both Medicaid-eligible and non-Medicaid-eligible individuals may qualify for the program. There is only one statewide SHP plan in operation. In addition to the 1915(b) waiver and the State-sponsored SHP, Michigan has a waiver for the developmentally disabled and one for adults with disabilities. Michigan=s waiver targeting aged and physically disabled persons covers more than 12,000 individuals. Rather than targeting a specific illness or condition, the waiver program has established need-based criteria to determine eligibility. While individuals with HIV/AIDS may be eligible, HCFA regional office staff indicated that the waiver was primarily serving adults with physical disabilities.

2.5 Unique State Considerations

The Department is billing Medicaid for administrative case management services but has elected to bill under its service match rather than under the administrative case management match. HCFA allows the State to decide how to bill for administrative case management services. Michigan=s Federal medical assistance percentage (FMAP) is 55.4 percent, while administrative case management is matched at 50 percent. Administrative case management billed under the service procedure (55.4-percent match) does not include all the activities that might be covered if the services provided were billed under the administrative case management procedure.

Documentation of the time committed to Medicaid activities is a requirement for reimbursement for administrative case management, regardless of how the State bills for these services. Michigan uses time

sheets for documentation of time devoted by health staff to Medicaid-related activities, except for health staff who are 100-percent committed to Medicaid-related activities. The fact that they are able to use time sheets supplied by the Medicaid agency simplifies the process substantially. There appears to be a good partnership between the Medicaid agency and the health agencies on ways to maximize Federal dollars. Local health departments, unfortunately, have not been billing for administrative case management services.

Under the targeted case management option, the State has included a category covering individuals who meet Aspecified criteria.@ Again, while individuals with HIV/AIDS may be eligible, HCFA regional office staff indicated that primarily adults with physical disabilities are receiving targeted case management.

3. STATE BACKGROUNDC TEXAS

This section provides an overview of the third-party payment programs active in the State of Texas.

3.1 The Medicaid Picture

Texas has a population of approximately 19.6 million. Medicaid enrollment in the State is approximately 1.7 million. Only 25 to 30 percent of the Medicaid population are enrolled in managed care. In Texas, managed care may be in the form of a fully capitated HMO, a partially capitated HMO, or a PCCM plan. Frequently, individuals have a choice of an HMO or a PCCM plan. About 25 percent of the State=s population are uninsured (in this border State, there is a significant undocumented population). The State=s Federal Medicaid match rate is 61 percent. Total Medicaid expenditures (State and Federal funds) in Texas for FY 1998 were $10.354 billion. DSH funds sent to hospitals serving the uninsured and Medicaid-eligible individuals in the State for FY 1998 were $1.439 billion, or a comparatively high 13.9 percent of total Medicaid expenditures in the State. The State=s matching dollars for the DSH funds come exclusively from tax dollars put up by nine hospital districts across the State by means of an ad valorem county property tax. While hospital districts receive more funds through DSH payments than they put in, decreases in DSH funds under the 1997 Balanced Budget Act and recent reductions in county property taxes, at least in the case of Harris County (Houston) by order of the county commissioners, have meant significant decreases in available funds for hospital district institutions and programs.

3.2 The HRSA Grants Picture

A full array of HRSA grantees are operational within the State. These programs are described in the sections that follow.

3.2.1 Maternal and Child Health Programs

The State Title V block grant is approximately $37 million. The maintenance-of-effort funding for the State is $40,208,728. In FY 1999 the State appropriated $57,700,000 for MCH activities. The State has an approximately $17.5 million overmatch that can be used for additional State Title XIX matching. The State reportedly is using the $17.5 million as matching funds for its CHIP.

The Title V Program contracts for MCH services, which include family planning services; prenatal, preventive, and primary child health care; and case management. Providers include local health departments and other community-based providers, which bill on a fee-for-service basis under a contract ceiling. Services are provided to clients with incomes below 185 percent of the Federal poverty level (FPL) who are not eligible for Medicaid. Contractors are required to screen for CHIP eligibility and to refer to the CHIP (see 6.2.2 below). The Texas Department of Health (TDH) MCH Program serves between 10 and 15 percent of the children in the State with family income below 185 percent of the FPL who are not covered by Medicaid.

As part of its Medicaid Program, TDH provides services to children with special health care needs with family income below 200 percent of the FPL. Undocumented children are unable to receive these services.

The State plans to expand its targeted case management program to include children with special health care needs up to the age of 16. It currently provides targeted case management services only for high-risk pregnant women and high-risk children under the age of one. In Fiscal Year 1999, there were three Healthy Start grantees in Texas, one each in Dallas, Fort Worth, and Galveston.

3.2.2 HIV/AIDS

Austin, Dallas, Fort Worth, Houston, and San Antonio are Title I Ryan White CARE Act cities. There are seven Title III grantees in Texas, one each in Austin, Dallas, El Paso, Fort Worth, Harlingen, Houston, and San Antonio. Funding under the Ryan White CARE Act in FY 1999 was $93,100,509. Texas is the only State in this study that does not have a waiver to provide services to individuals who have AIDS or are symptomatic HIV patients.

All children with family income below 200 percent of the FPL are eligible for Medicaid or the CHIP. Phase 1 of the CHIP is a Medicaid expansion covering all children with family income under 100 percent of the FPL through the age of 19 (the expansion adds children between the ages of 15 and 19). Phase 2, starting later this year, will cover all children 19 and under with family income below 200 percent of the FPL. Phase 2 is not an expansion of the State=s Medicaid program.

3.2.3 Primary Care (Including the Bureau of Primary Health Care and the Office of Rural Health)

In Fiscal Year 1999, Texas received $58,653,304 from HRSA to support primary care centers and $1,117,082 for rural health activities. The Bureau of Primary Health Care is supporting 39 primary care

centers in Texas and seven homeless projects (two in Lubbock and one each in Dallas, El Paso, Houston, Plainview, and San Antonio). The Office of Rural Health supported two rural health outreach projects (in Albany and Fort Stockton).

3.3 The Medicaid Managed Care/Waivers Picture

The Texas Medicaid Program is administered through TDH. TDH has divided the program into a fee-for-service bureau and a managed care bureau. Waivers for mandatory Medicaid managed care are typically organized by major population centers, or Aservice centers,@ and their contiguous counties. There are eight 1915(b) waivers for Texas, covering Austin, Dallas, El Paso, Forth Worth, Galveston, Houston, Lubbock, and San Antonio and their surrounding counties. The Austin and Forth Worth service centers provide HMO managed care only. Most of the other service areas provide a choice of HMO care or PCCM.

Under 1915(b) and 1915(c) waivers, the State also runs Star Plus through the Houston service center. Star Plus has an enrollment of about 55,000 adult SSI recipients. The program provides acute and long-term care and emphasizes care coordination and case management services. There are a number of other, smaller HCB services waiver programs, including a 1915(c) waiver for children with special health care needs that provides care for medically dependent children up to the age of one and children over the age of one who are not otherwise covered by insurance. Over 40 percent of the State=s maternal and child health budget is allocated to this program. The State has indicated that it is planning to expand both services offered under this waiver and its Medicaid targeted case management benefit to include children up to the age of 16. Currently, targeted case management services are only for high-risk pregnant women and children up to age one. Local health departments can bill for targeted case management; however, the required documentation is extensive and somewhat burdensome. Texas is the only State studied that does not have a waiver to provide services to individuals who have AIDS or are symptomatic HIV patients.

3.4 Home and Community-Based Services Waivers C Section 1915(c)

Over 40 percent of the State=s maternal and child health budget is allocated to children with special health care needs. The State has an HCB Services waiver for medically dependent children up to the age of one and provides case management services through a modification in the State plan (targeted case management). For children over the age of one who are not covered by insurance, the State assumes some of the cost for the services. The State plans to expand its waiver and targeted case management programs to include children with special health care needs up to the age of 16.

Included in the State=s targeted case management system are enhanced prenatal and postnatal care services to high-risk pregnant women and their children up to the age of one. The local health departments can bill for targeted case management services, but there are many barriers, including the need to provide extensive documentation. The State pays $35 for a targeted case management encounter and $56 for a medical case management encounter.

All children with family income below 200 percent of the FPL are eligible for Medicaid or the CHIP. Phase 1 of the CHIP is a Medicaid expansion covering all children with family income under 100 percent of the FPL through the age of 19 (the expansion adds children between the ages of 15 and 19). Phase 2, starting later this year, will cover all children ages 19 years and under with family income below 200 percent of the FPL. Phase 2 is not an expansion of the State=s Medicaid Program.

3.5 Unique State Considerations

The State=s Medicaid program has a limit of three drug prescriptions per month. For the sick or frail individual, this may present a hardship. The Texas Primary Care Association has been able to creatively expand prescription coverage for FQHC patients. Tobacco settlement funds are being used in the State to support indigent care through payments to the counties.

There is a State moratorium on managed care program expansion until the legislature meets again in January 2001. Despite the high number of waivers, much of the State, including most of the rural areas, is not under mandatory managed care. In addition, certain populations may choose managed care or fee-for-service, for example, SSI recipients outside of the Star Plus service area. Children in foster care are always treated under fee-for-service and may not be treated under managed care.
The Texas Department of Health has created administrative barriers that have precluded the local health departments from collecting any administrative case management reimbursement.